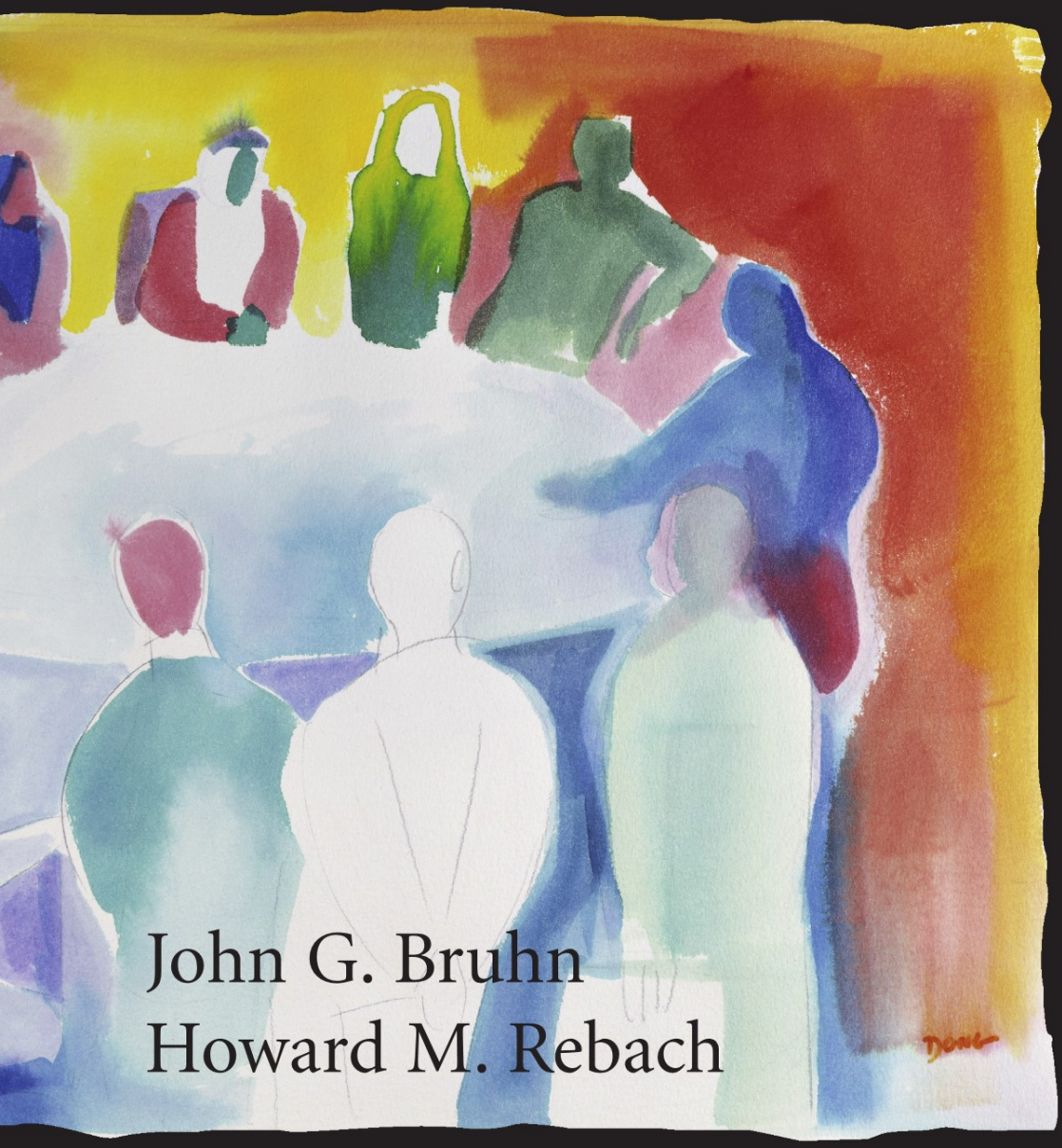
Sociological Practice

Intervention and Social Change



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Springer

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To John F. Glass for his leadership
and contributions to the field of clinical sociology
— JGB

To Katherine, and to my students
— HMR

Preface

Slightly more than a decade ago, our text, *Clinical Sociology: An Agenda For Action*, was published by Plenum Academic Publishers. Since that time (1996), the Clinical Sociology Association has changed its name to the Sociological Practice Association and has merged with the Society for Applied Sociology. This new organization and its joint journal became effective in 2005. Therefore, as we began planning a second edition to our text, we decided it would be only appropriate to change its original title to *Sociological Practice: Intervention and Social Change*.

Intervention to bring about beneficial social change is the theme of this new edition of our text. We have attempted to write a "how to do it" type of book for students who are interested in careers in sociological practice. We emphasize the importance of establishing a theoretical foundation for planning an intervention for each client, followed by an extensive assessment, fact-finding, and dialogue with the client in selecting an appropriate intervention(s), establishing an ethical practitioner-client relationship, and a timetable of expectations and financial costs detailed in a written contract. Every intervention also involves an evaluation in order to determine its effectiveness and feedback for improvement with future clients. We emphasize how critical it is for practitioners to be ethical in all of their interactions as these impact referrals and the reputations of both the practitioner and the profession.

Since the text conveys both the complexities of sociological practice as well as numerous choices, we use examples throughout the narrative part of the text as well as in Application Boxes. Application Boxes provide the reader with ideas, approaches, methods, and outcomes of interventions that were successful or unsuccessful.

No text in a broad and dynamic field can claim to be complete or current. Facts and experiences change as we write. However, we have benefited in our revised edition from the suggestions and critiques of both students and colleagues who have used the text. We hope that we have met their expectations.

As sociological practitioners we are excited about the continually growing need for sociological consultation, intervention, advocacy, teaching, and research in today's world. Yet, there continues to be skepticism and opposition from

colleagues to intervention as a relevant role for sociologists. It is our experience, that students on the other hand, see the relevance and importance of sociology in its applications. We hope this text will help all audiences recognize that sociologists, as professionals and citizens, are becoming engaged in an action agenda.

John G. Bruhn
Howard M. Rebach

Acknowledgments

We are grateful for the detailed comments of three anonymous reviewers of our proposal for a second edition of this book and comments on the strengths and weaknesses of the first edition from many students in our classes. Barbara Strachan read several chapters for the second edition and provided valuable suggestions from a student's viewpoint. Dr. Beverley Johnson also provided many suggestions for improving the second edition. Bob Rebach designed and produced the graphs in this edition. We appreciate his professional work. Tracy Grindle, our typist for several projects, worked patiently with us through several drafts. We are fortunate to have someone who is so dedicated to excellence in her work. We thank her for her substantial contribution in producing this volume.

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The Application of Sociology

Introduction

Sociological practice is the application of sociological theory, methods, and research for direct intervention to bring about positive social change for the solution of social problems. What distinguishes sociological practice is the direct involvement of the sociologist in planning and implementing problem solving to bring about social change. In this chapter we provide a broad overview of sociological practice and concepts that frame it. We begin with social problems.

Social Problems

Miringoff and co-workers (Miringoff, Miringoff, & Opdycke, 2003) at the Fordham Institute for Innovation in Social Policy assembled data on a set of social indicators and conducted surveys and developed their *Index of Social Health* to assess the general state of the social health of the nation. The set of social indicators included the infant mortality rate, the child poverty rate, the income inequality index, the extent of health care coverage, and so on. Taken together, the factors included represent a reasonable set of trends in social problems. These researchers concluded that the social health of the nation had declined and that, " . . . our most serious social problems, such as child poverty, child abuse, health insurance coverage, average weekly wages, and income inequality, have worsened markedly over the past three decades" (Miringoff et al., 2003: 15).

Similarly, Eitzen and Leedham (2001) reviewed data comparing 19 industrialized nations. They noted that, "the United States has more serious social problems than are found in countries most similar to it." While the United States ranked first in real wealth, it also ranked first in such social problems as poverty and child poverty, infant mortality, homelessness, urban deterioration, violent crimes, and environmental deterioration (Eitzen & Leedham, 2001: 4–5).

This brief review of the state of social problems should be a call to action for societal members in general, and sociologists in particular, to address social

problems. The times call for action. The early sociologists and the sociologists of the University of Chicago School of Human Ecology directed their work to the problems of their times. We cannot ignore the fact that sociological studies have a direct bearing on the issues that face contemporary society. Sociological studies can help uncover the causes of social problems and suggest solutions.

Since we have defined sociological practice as helping to solve social problems, it is important to clarify what is and what is not a social problem. A person who needs medical attention but cannot obtain access to health care may be aware that he or she has a problem. However, when whole categories of people are similarly affected, we begin to identify the presence of more than an individual problem. Thus, to be a social problem, some condition must affect a significant proportion of the members of a social system.

The key feature that helps us recognize some condition as a social problem is that the condition arises from and is maintained by existing social arrangements. By "social arrangements" we refer to the prevailing norms, rules, policies, customs, practices, ideologies, and all the other factors that pattern social life. For example, in most of the industrialized nations of the world, all citizens are covered by some form of national health plan. However, in the United States, no such plan exists; ideologies, policies, and legislation do not support guaranteed general provision of health care coverage. According to the United States Census Bureau in 2004, about 16% of the population had no health insurance coverage at all – about 45.8 million people including 8.3 million children (DeNavas-Walt, Proctor, & Lee, 2005).

The view that social problems arise and are maintained by social arrangements also underscores the idea that, when whole categories of people are similarly affected we must look to social arrangements as a cause. For example, racial and ethnic differences in health care coverage exist. The uninsured rate for non-Hispanic whites was 11.3% compared to 19.7% for African Americans and 32.7% for Hispanics. The average income for females is about two-thirds that of the average income for males. Ongoing discriminatory practices are among the social arrangements responsible.

Finally, it is not the objective events that determine what is or what is not a social problem. A social process is involved in the recognition and labeling of some condition as a social problem. The condition is recognized and labeled (and stigmatized) by societal members with the power to label and make their labels stick. Care needs to be taken here. That is, power relations within a social system may determine what does and what does not get defined as a social problem. This, itself, may be a social problem. Elites may define the problem, set the agenda for attention and problem solving and guide policy and intervention that reflect elite interests. The needs and concerns of the powerless and disenfranchised may be ignored. For example, poverty, slum housing, and deteriorating neighborhoods may be defined as a problem while the laws and tax codes that allow and encourage absentee slumlords to let their properties deteriorate may be ignored.

The Sociological Practice Approach

Sociological practice is one model in the larger set of *applied sociology.* One very important and useful form of sociological practice has been applied social research. In this model, these sociologists use their research skills to provide clients with data that describe social systems, problem areas, and the need for change. Clients use these data for planning and developing policies and programs for change. Social researchers also conduct evaluation research to determine the effectiveness of programs that can further guide program development. What is unique about sociological practice is the active and ongoing participation with client systems, perhaps as part of a team, using sociological insights in helping to plan and actually implement strategies for change and problem solving. Sociological practice includes active, ongoing participation as an agent of intervention and change.

It is not unusual for sociologists, as citizens with genuine concern for people's well-being, to choose to apply their training to social problems that concern them. For example, Dentler (2005) described applying sociology to his personal commitment to racial justice, and work on school desegregation and educational opportunity for minorities and women. However, working with clients usually frames sociological intervention. Thus, sociological practice has a structuring formula: Professionals, in some way, make their professional presence and availability known. Individuals or groups make contact to seek help with problems they believe to be within the scope of the professional's expertise.

Intervention work focuses attention on behaviors or conditions that some person or group has defined as problematic. Additionally, the person or group faced with the problem comes to realize the need for professional assistance; that problem solution, perhaps, requires specialized knowledge and skills that are beyond their own resources. For example, a couple may be experiencing severe marital discord; the staff of an agency may be severely discontented, leading to internal conflict and reduced effectiveness; a community group or agency may want to address issues of child health at the community level; a school and a family may be unable to cope with "an impossible child;" a community may be beset with drug and gang activity and want to take back its neighborhood; and on and on. If a professional and client agree to work together, they form a professional relationship and begin to work together. It is a process, the goal of which is problem solving and change.

Definition of the identity of the client may vary. We find it useful to distinguish between the terms *client* and *client system.* The client may be the one who brings the problem to the attention of the sociological practitioner (and may be the one who ultimately pays the bills). The client system refers to those coactors who participate in the problem, may be the ones who have defined the condition as a problem, and may be involved in planning or participating in the intervention. They may be the ones to change or be affected by change.

Although the structuring formula seems simple and straightforward, it may not be. The decision to seek professional help involves a commitment of resources – time,

energy, and, often, money. This is weighed against the costs of failing to seek professional help. Thus, the initial contact is the result of a subjective cost/benefit analysis by prospective clients or members of the client system. Their analysis is ongoing. Whether the relationship goes beyond the initial contact, and whether it continues at any point in the process, involves the continuing estimation of whether the payoffs outweigh the costs. These calculations are influenced by estimates of the professional's skills and expertise, the nature of the relationship with the professional, the willingness of parties to work toward problem solution and change, and their estimate of the likelihood of reaching the goal as well as its value for them. Several variables enter in.

One variable that affects the intervention is who wants change and who is the target for change. Another closely related variable is the degree of voluntary participation on the part of the target for change. Clients may have made a free choice whether, from whom, and when to seek help. They may have recognized the existence of a problem beyond their present ability to solve and decided that they could benefit from professional help. On the other hand, their involvement may stem from coercion by more powerful agents. For example, individuals or families may be compelled by courts or social services agencies to seek professional services or suffer some aversive consequence. Or, upper management of a company or agency may impose professional intervention on a work unit to achieve some of management's objectives. Sometimes powerful authority agents want change, but sometimes it is the less powerful that want change and are opposed by more powerful interests who do not want change. For example, community residents may be confronted by a problem but encounter resistance to change by political or business interests. The degree of voluntary participation will affect the willingness of various actors to continue with and cooperate in the change process. It will also affect the evaluation of, and response to, the intervention agent.

The issue may be, "Who owns the problem?" Suppose the target for change is an adolescent boy who has been dismissed from school, has been involved in the juvenile justice system, has been a trial and an embarrassment for his mother, and has been court ordered to "treatment." The practitioner is supposed to "fix" him. The parent, the school staff, and the juvenile justice system define the youth's behavior as "the problem" and want change–not necessarily in their own, but in this troublesome boy's behavior. From the youth's perspective, the problem may be that he is being hassled by these adults and their systems. His behavior may be highly adaptive within the context of his family, neighborhood, community, school, and the peer network. His motivation to participate in any intervention may be quite low.

One important feature of sociological practice, then, is the development of a working relationship between one or more professional workers and one or more members of the client system. The process of the work and its outcomes are based upon the nature of the relationship that emerges. The exact nature of the relationship will vary with the problem, clients' preferences, and the situation. Here, we assert, that it must be a relationship of trust between equal partners. Even where

there is trust, confidence, cooperation, and willingness, the task will be difficult. Where there is suspicion and hostility, it will be impossible.

Another important feature of sociological practice is intervention itself.

On Intervention

We begin with the idea that social problems have a social base and that social change is possible. Social arrangements are not immutable. Eitzen and Baca Zinn (2004:564) reminded us, social arrangements are created by people and people can change them. Sociological practitioners are change agents. Intervention is about changes in social arrangements and/or behavior change on the part of one or more members of the client system. It means the construction of new social arrangements. Intervention means the people involved do things that cause change in a desired direction to occur. Intervention is a process. It requires careful and thorough analysis of the problem situation, the availability of resources, and a hard-nosed determination of what is possible. Intervention also requires setting realistic objectives, developing and implementing strategies to achieve the objectives and continually monitoring the process to see if it is working. Intervention, as a professional process, should follow from problem definition based on data gathered by acceptable methods to assure reliability and validity. Recommendations should follow from a sound theoretical base reinforced by supporting empirical results.

To develop strategies for change, intervention must begin with a thorough assessment. Development of strategies for change requires a deep understanding of existing conditions, the context, and the social system. It also requires careful definition of the problem and a clear understanding of the factors that maintain the problem. It requires a clear understanding of what needs to be changed and an even sharper awareness of what can (and cannot) be changed.

But, as Eitzen and Baca Zinn also reminded us, social change is a social process; problem solution requires collective action. Sociological intervention is a dynamic social process of collaboration between the sociological practitioner and members of the client system. To be successful, the sociological practitioner, as a change agent, must be able to negotiate effective working relationships. The sociological practitioner brings relevant sociological insights based on practice knowledge and experience. Problem definitions are determined and objectives set through assessment, presentation of results, and negotiation with clients. The professional's knowledge and experience may result in recommendations for action, with the actual plan developed in negotiation with clients. The purpose is to construct arrangements that will relieve the problem and benefit the client. But change, even desired and beneficial change, is sometimes difficult for people. And, the more complex the social system, the more people involved, the greater the difficulty in instituting change. The relative effectiveness of the intervention depends on the quality of the relationships that are established. And, in multilevel systems, care must be

taken that changes instituted to solve problems at one level do not create difficult consequences and new problems at other levels.

From the practitioner's point of view, clients need to be open and cooperative in providing information, be prepared to work for change, and be willing to enter into a working relationship. Clients must have confidence in and trust the professional. They must feel safe in being open to change. They must feel valued and believe that their unique circumstances are understood and respected. Clients must also feel that they have a stake in and stand to benefit from the relationship and the recommended activities. A model of status inequality – professionals (high status) dictating to clients (low status) – in most cases will probably fail. To be effective, working relationships must be relationships of equality, democratic in character, and clients' autonomy, ability to problem-solve, and to make choices, must be respected.

It is important that clients believe that they have received proper attention and have been understood. Their future motivation for work may depend on whether they think they have been correctly understood and are receiving the help that they initially sought.

On Scientific Sociology and Practice

Sociological practice, like other forms of applied sociology, has its basis in the field of sociology. Sociology, broadly defined, is the systematic study of the social behavior of individuals, the workings of social groups, organizations, cultures, and societies, and the influence of these human institutions on individual and group behaviors (Kammeyer, Ritzer, & Yetman, 1994:2). In other words, scientific sociology is the study of human behavior. Sociological practitioners use the methods, principles, and knowledge base of sociology to address problems that arise and are maintained by existing social arrangements. That is, sociological practitioners address social problems.

Sociological practice should and does stem directly from the application of the scientific methods of sociology. However, intervention work on a "case" differs from more theoretical scientific work. Each case is unique, in its own way, a rare event. While the theoretical work of any science is to seek law-like generalizations about the properties and functioning of the universe–the social universe in the case of sociology–intervention work addresses a relatively unique situation. The distinction between intervention work and scientific work is the difference between *ideographic* and *nomothetic* models of explanation. Science, including the social sciences, usually uses the nomothetic model. Ideographic explanation seeks to explain the cause of a unique event or outcome in terms of a unique sequence of events that led up to the outcome to be explained. Thus, the success or failure of an organization or social movement would be explained in terms of the observable events that took place over time leading up to the observed outcome. An individual's present behavior would be explained in terms of the person's specific socialization experiences and developmental path.

The ideographic model of explanation addresses the unique case. The nomothetic model seeks to explain general classes of actions or events in terms of cause and effect. The statements, family solidarity and community cohesion are positively associated with indicators of health; rapid social change and the breakup of family solidarity and community cohesion are associated with an increase in illness (Wolf & Bruhn, 1992) are an example of nomothetic explanation. The statements assert a probabilistic relationship between causal variables and outcome variables. Moreover, the statements imply a general relationship between certain antecedent conditions and consequences that is not tied to time or place.

Work with a single case cannot be considered scientific in the sense of developing empirical generalizations about populations. But, the *scientific method* should guide sociologists working with a case. This involves the careful collection of data, theory development, and the formulation and testing of hypotheses. Emile Durkheim's *Rules* (1893/1966) are relevant. Avoid preconceived notions; find and build on the facts to construct an understanding of a case. Establish valid links between observable antecedent conditions and observable consequences. Conduct careful measurement to determine if hypothesized interventions do, indeed, lead to proposed outcomes.

While work with unique cases is not exactly the same as scientific investigation, the techniques and concern for the scientific method should transfer. In addition, the findings of scientific investigation should help to inform understanding of a case and selection of strategies for change. Thus, findings from studies of the differential effects of exposure to stress and stressful life events on men and women, especially the stressful effects of poverty and discrimination may inform the understanding of family conflict, health/mental health, and intervention strategies (Lantz, House, Mero, & Williams, 2005).

On Theory and Practice

Knowledge of theory, Dotzler (2002:247) wrote, is what makes a professional "an artful practitioner." McLain (2002) also pointed out that sociological interventions are "deeply grounded" in sociological theory, which is " . . . critical for the amelioration of social problems." Turner (2001) expressed a view we agree with when he argued for social engineering to be a part of sociology. Engineering, wrote Turner, " . . . involves the application of knowledge about the properties of the universe to the practical problem of building something." Well, sociological practitioners are not likely to construct bridges or electronic networks, but we do attempt to construct desirable social arrangements. What is needed, as Turner stated, are powerful theoretical principles, confidence that they are correct based on empirical findings, and experience with application of principles to real problems. Moreover, practitioners need to be able to assess the unique situation of a case for its generic properties and how they serve as instances of the generic.

Akers (2005:26) pointed out that all practices are based on theories or make certain assumptions about the causes of behavior and what it takes to alter or prevent certain behaviors. Akers' point is worth noting. We can extend his idea to point out that all recommendations for action, for practice, are based on some ideas about the nature of reality and about cause and effect. Ideologies and what, today, we might call superstitions or myths have certainly been applied, throughout history, as bases for policies and problem solving. Today, we are still not free of the effects of the ideology of Social Darwinism or immorality as causes of poverty. However, science is about theory, not ideology.

Sociological practice should be driven by theory. The goal of any scientific discipline is the construction of theory. By the term *theory* we mean a set of general statements that explain an observable phenomenon. A theory is an explanation of why observable events occur in the way that they do. It includes at least some law-like generalizations. The statements of a theory are usually abstract; they are not bound to time or place. However, a theory rests on a base of empirical evidence that support the propositions and generalizations. A theory does several things: First, a good theory describes the reality it addresses. Second, it provides a taxonomy or classification system that directs attention to the important elements and concepts of the phenomenon to be considered. Third, it provides an explanation of events that help create understanding of how things happen the way that they do. And, fourth, a good theory provides predictions about the relationships between antecedent conditions and consequences. A theory, then, should provide a guide to further action.

Research is the usual guide to action in the development of theory. Predictions about specific consequences of certain conditions can be derived from the propositions of a theory. These predictions, or hypotheses, are tested, and whether supported or not, contribute to the development of the theory. Another guide to further action is the application of theory to practice. As practitioners, we hold that the ultimate test of a theory is its application to practice. Thus, labeling theory predicts that deviant behavior will accelerate behind receiving a deviant label, being stigmatized, which results in developing a deviant identity that leads to further deviant acting. Present juvenile diversion programs that divert juveniles from court processing and juvenile facilities are specific applications of labeling theory. To the extent that juvenile diversion programs effectively prevent further delinquency and promotion to adult offending, to that extent labeling theory is reinforced.

Like any theory, labeling theory provides statements about the relationship between antecedent conditions and consequences. These statements are of the form "If A, then B, under conditions C." Ethical and effective practice requires that practitioners have a theoretical basis and empirical support of such statements to guide recommendations to clients. An understanding of the relationship between certain conditions and their consequences not only suggests what to change, but should point the way to change strategies. As practitioners wander

into the *terra incognita* of a case, a theory can provide a sort of map of the territory. Anderson and Rouse (1988:137) elaborated on this point:

> Sociological theories offer basic models of social behavior which can influence counseling *goals* and provide a *rationale* for selection and use of particular techniques. Theories serve to clarify and open to critical evaluation the assumptions about social reality implicit in practice. Theories make available to practitioners conceptual frameworks for *understanding* how, or why, certain interventions lead to, or fail to produce, desired changes. Theories help to *organize* various techniques and exercises into a consistent, integrated approach. [emphasis in original]

Practice can also feed back to theory construction. The materials, insights, and results obtained in practice experience can illuminate theory. Albion Small (1896/1985:37) felt this strongly when he argued:

> The most impressive lesson which I have learned in the vast sociological laboratory which the city of Chicago constitutes is that action, not speculation, is the supreme teacher. If men will be the most productive scholars in any department of the social sciences, let them gain time and material by cooperating in the social work of their community.

In sum, research, theory, and practice together offer the possibility of positive social change. At the same time, the inclusion of practice into the research-theory process offers the possibility of further development of our understanding of social life.

The Macro-Micro Continuum

The distress felt by persons without health care coverage reminds us of C. Wright Mills' (1959) point that personal problems often connect to social problems. Programs and policies, social arrangements and decisions taken at the national level have consequences for individuals, families, organizations, and communities as well as the nation as a whole. The social problems addressed by the Fordham researchers are national in scope, but problems may arise from existing social arrangements within a family or a neighborhood, a school or a company or a community. Social life, and, thus, sociological analysis and intervention, includes many levels of social organization. We use the concept of the sociological spectrum, the *macro-micro continuum,* to describe this variability. Table 1.1 illustrates.

As the levels of analysis progress from the microlevel to the macrolevel, social structures increase in scope, complexity, and, perhaps the time-span of their existence. For example, a nuclear family has a certain structure, set of role relationships, and division of labor. By comparison, a multi-generational kinship network shows greater complexity; there is a larger set of relationships, more complex division of labor and a greater time-span.

The macro end of the continuum considers large social units at the societal and intersocietal levels of analysis. Macrosocial structures include national or world economic systems, media systems, or stratification systems. They also include

TABLE 1.1. The macro-micro continuum.

Level of orientation	Types of systems	Examples of structures	Issues for sociological practice
MACRO	World systems	World economy	• international trade relations • international conflict resolutions
	National systems	• societies, social institutions such as education, political, legal, economic	• policy • legislation • customs & practices • discrimination • social problems: poverty, homelessness, violence and terrorism, immigration, ethnic conflict, civil rights, health & welfare policies, law enforcement, unemployment
	Large corporate structures	• political sub-divisions (e.g. states, counties, cities) • national or multinational corporations	• intra- or interinstitutional conflict, territorial conflict, culture clashes, interdisciplinary activities, organiztional mergers
MESO	Small corporate structures	• businesses • schools • universities • communities	• inter-group conflict, resource development including human resources, community organization and action such as drug & alcohol, or delinquency, crime prevention or general community improvement
	Secondary groups	• work units • neighborhoods • civic organizations	• intra- & intergroup cooperation • communication & relationships • political action • problem solving • group solidarity
	Primary groups	• families • couples • peer groups	• improving family/group functioning & relations • interface with societal structures • conflict resolution
MICRO	Individuals	• individuals	• socialization/resocialization • behavior change • acquire/develop skills • social development

broad scale social institutions such as political-legal systems, religions, national educational systems, social welfare systems, etc. The organization and change of political economies or ethnic group relations are also examples of topics that may be addressed at this level. Other examples include interrelationships among and changes of social institutions such as religions, communication media, social

welfare, political orders, and economic orders. Macrosociological topics may also include wide-spread social change such as changing norms or role definitions over time. Efforts to address racism and sexism throughout the society are examples. In general, the macrolevel incorporates a broad sweep of large structures and may include long time-spans.

At the micro end of the continuum are small social units, the smallest of which is the individual as a social actor and member of a specific social system. Beyond the individual, the microlevel refers to social units that are characterized by face-to-face interaction and primary group relationships among their members. Couples, dyads, and families are also examples of microsocial structures. Microsociological topics include role relationships, interaction processes, dominance structures, and socialization processes. Sociological approaches to intrapersonal processes such as self esteem (Rosenberg, 1990) and emotions (Hochschild, 1979) are additional topics at the microlevel.

For example, Johnson (2001) and Fein (1990) have described sociological practice approaches to working with individuals. Johnson noted that "patterns of thinking, feeling, and behaving are strongly influenced by prevailing socio-cultural themes, values, ideals, objectives, rituals, and institutions" (2001:97). Social identities, roles, relationships, and group memberships and adaptations to social contexts are important influences in the way people assign or create meaning which influences feelings and behaviors. Johnson also focused on the language constructions that clients use to describe themselves and their emotions and situations. Johnson conceptualized individual problems as socioemotional disorders. Social problems at the individual level " . . . stem from feelings, emotions, cognitions, and symbolic representations . . . ." that develop from social interactions and have social consequences.

In between the macro and the micro ends of the continuum is the broad area that we label meso or midlevel structures such as networks, communities, and organizations. Sociological practitioners may more often be involved with mesolevel structures than with issues at either extreme. Mesolevel structures range from small secondary groups, such as departments, work units, or clubs, to corporations, government agencies, universities, or communities. Mesolevel issues may involve organizational health and effectiveness, social change and problem solving within the social system, or the use of a group or an organization to facilitate change in members or as an agent of larger social change. Mesolevel issues may also involve intergroup relations including boundary conflicts between groups or organizations or between levels within an organization.

The Resource Fathers Program is a community-based program that worked with low income or unemployed, unwed fathers, especially African American men (Sheppard, Sims-Boykin, Zambrana, & Adams, 2004). The program, part of the Virginia Healthy Start Initiative, illustrates the involvement of several levels. The stereotype had been that these unwed fathers are unwilling to become involved with their children and unwilling to accept parental responsibilities. However, research showed the stereotype to be inaccurate. The goals of the program were to increase " . . . fathers' involvement during pregnancy and

childrearing [and educate] men on the importance of maintaining loving, caring relationships with their children and positive co-parenting relationships with the mothers of their children" (Sheppard et al., 2004:32). The low income fathers faced several obstacles to parenting including joblessness, few had positive role models, and little social support. The program was instituted to affect the behavior of the individual participants. However, the mentoring and peer support that the men received affected them and their children, family, and community as well.

On Levels and Intervention

It should be obvious that the scope and complexity of the social system will determine approaches to intervention and recommendations to clients. Indeed, part of defining problems and identifying objectives depends on identifying where on the continuum the problem lies. Sometimes it is not immediately evident. This was illustrated by the case of a 14 year-old girl who was having problems in school. She was clearly diagnosed as ADHD with learning disabilities by both the school system psychologist and an independent evaluator; she qualified for special education services. However, the school refused to provide such services on the grounds that its resources were already taxed to the limit. Repeated conferences and requests for help for this girl led nowhere and it was recommended that the parents consult their lawyer. It eventually required a court order to the local school system to comply with the provisions of the Individuals with Disabilities Education Act (IDEA) for this child to receive educational services that addressed her problems. In this case, problem solution required going beyond the client-level, beyond the school system level and required legal intervention.

The kinds of social problems described in the opening section of this chapter are examples of macrolevel issues. Interventions to address these problems would probably have to be national in scope. They would need to address the ideologies that underlie the present policies and practices that maintain the present problems. Social change would require broad-scale political mobilization to build vocal constituencies advocating for policy changes and enabling legislation. Public education campaigns and mass media would probably be necessary. And change may take a long time, require persistence, and significant organization and maintenance of support. Such intervention is difficult, but not impossible. The history of the United States features several prominent examples such as the Abolition movement, the Temperance movement, and the Civil Rights movement as well as anti-war movements.

Launching a community program to address infant and child health might illustrate community work as well as the interaction of levels. Multiple levels are involved. Concerns will certainly include behavioral choices by individual adults regarding health-risk behaviors such as alcohol, drug, and tobacco use, especially by pregnant women. Psychosocial stressors on pregnant women also affect fetal development. Personal poverty and living in an impoverished neighborhood with

frequent crime and violence and lack of social support are examples of such stressors, especially if the environment engenders chronic fear. Timely and adequate prenatal care is an additional factor which touches on issues of health-care coverage and access to providers. Matters of public policy and legislation are involved as well as market forces that influence the distribution of medical services providers within a community.

For the program to work, community residents have to "buy in" to the program. Intervention at the community or neighborhood level requires community organization skills and techniques. Assessment requires development of detailed knowledge of the structure of the community, identification of stakeholders, legitimizers, and opinion leaders. Program development may require obtaining cooperation of agencies serving the community such as health departments, social services departments, school systems, police, etc. Intervention may require public education to heighten awareness of the problem and build a supportive constituency and a cooperative base among community residents. Program planning should include local people. Development of the program will require cultural sensitivity. Program components and goals must be acceptable to and show respect for community members and obtain the approval of key legitimizers and opinion leaders within the community.

Whether attention is focused at the individual or personal level or at broader, social system levels, the various levels are linked. The nature of the macro-micro linkages is increasingly important as the etiologies, prevention, and solutions to contemporary social problems in the United States and elsewhere lie in understanding the interfaces and linkages between individual behavior and societal factors. For example, problems of pollution, global warming, environmental degradation and resource depletion may require national and international governmental attention, but problem solution will also require changes in choices made by individuals and have far-reaching effects on communities, families, and individuals as well as on nations.

On the Interaction of Levels

Sociological intervention may take place at any location on the continuum. But, events at one level have implications for and affects on other levels. The levels are interrelated. Collins (1988:3–7) recognized this when he stated that " . . . microsociology overflows its boundaries into macrosociology . . . ," and that " . . . micro theory finds it less easy to ignore macro theory than vice versa." That is, individual or small group activity, attitudes, beliefs, definitions of self and context, preferences, life chances, and available range of choices are, to a large extent, structured by prevailing social, political, and economic structures, practices, events, and policies, mass media content, and sociocultural norms and role definitions. Thus, Collins stated, " . . . when we examine an individual, or situation, or thought process, in however micro detail, we tend to encounter elements which lead outward toward the wider society."

Church (2001) discussed the effects of macro-social change on the work of sociological practice. He expressed the view that most disciplines engaged in intervention do not take recognition of macro-social issues or their influence on people affected. Sociological practitioners were reminded of the sociological imagination, "a vivid awareness of the relationship between personal behavior and the social context in which it is framed" (Church, 2001:76). In addition, the importance of analysis across macro, meso, and microlevels, and high degrees of awareness of and commitment to such analysis was emphasized. The importance of analysis across levels cannot be understated. Where the primary unit of analysis is the individual (which often occurs even in work with groups), understanding is limited to the attitudes, motives, or other internal states of individuals, often to the neglect of the effects of social arrangements.

For example, the changes in the world economy and the place of the United States in it, as well as the changing nature of employment and disappearance of low-skilled and even industrial jobs–macrolevel processes–have had direct effects on individuals, families, and communities as well as schools, churches, and neighborhoods. Other economic changes now require both mothers and fathers to be employed outside the home. These economic changes have affected norms regarding child bearing, child rearing, marriage, and parental responsibilities. These macrolevel processes have taken place along side of an accelerated number of single parent households and latchkey kids. They come down to the specific conflict situations, role relationships, and childrearing in client families, as well as the socialization of children and youth. The self conceptions and behavioral choices of client children and youth – drug and alcohol use, gang membership, sexual precocity, delinquency – are potentially related to these macrolevel processes that affect families, neighborhoods, communities, and classes.

Similarly, mesolevel structures and processes may mediate between the macro and microlevels. The networks and organizations (mesolevel) that people belong to and identify with may transmit and interpret the normative order (macrolevel) to individuals and families (microlevel). These mesolevel structures may also provide prescriptions and orientations in their own right. Thus, a person's job, occupational group, professional association or union, church, school, community, class, etc. are all sources of influence on the individual's consciousness and social interactions.

The interplay of levels was the focus of a report by Stanley-Stevens, Yeatts, and Thibodeaux (1993) who noted that societal changes in the workplace and in the family were accompanied by a need for increased productivity, more women in the workforce, and conflicting demands of work and family. To implement a change from a more traditional management to self-managed work teams, and electronics plant trained the workers " . . . in listening skills, communication, and cooperation–all important interpersonal skills which can have positive impacts on family life." Stanley-Stevens, et al. found strong support for their hypothesis that the skills learned at work "spilled over" into benefits for workers' families. In addition, productivity and commitment among workers was increased at the plant. The authors recommended this approach for sociological practitioners

consulting with industries. The intervention exemplified how changes at one level affected other levels. The company was adapting to societal trends. The interaction of levels, that included societal trends, also involved the company, families, and individual employees – macro, meso, and microlevels.

Recognition of the interplay of levels is critical for sociologically informed practice. The client system is likely to be affected by broad social changes on the macrolevel, by various cultural and sub-cultural groupings (e.g. race, ethnicity, age, generation), by peer networks and primary group memberships, by the unique learning experiences of individuals, and the interpretations of situations by individuals. Whether intervention is with an individual, a family, or a larger group, it is important to the assessment of a case and the planning and delivery of an intervention that sociological practitioners pay attention to the interplay of levels. Assessment data should inform intervention planning and delivery. Full understanding of a case cannot be obtained by attention to the individual client only. Interventions should be culturally and individually acceptable and workable for clients within their social context. Interventions in larger systems should be examined for their impact on the groups and individuals that comprise these systems. Thus, Schuyler and Branigan (2003) emphasized the need to attend to individual, group, and system levels in interventions for organizational development and the introduction of change in organizations.

An Example of an Intervention Program

Two related social problems are child abuse and neglect and juvenile delinquency. Research has shown a steady increase in reported cases of child abuse and neglect. Additionally, research has shown that abused children are highly likely to show anti-social and delinquent behavior in adolescence and criminal behavior in adulthood. These findings suggested that reduction of child abuse and neglect can lead to a reduction in delinquency. The Nurturing Parenting Program, developed and reported on by Bavolek (2000) was created as a child abuse and neglect prevention program and a delinquency prevention program. Bavolek's report illustrates the application of social scientific research and theory to address social problems.

As part of the theoretical base, Bavolek began with the idea, supported by research findings, that parenting behaviors are learned, primarily in childhood; that is, adults learn how to parent based on the parenting behaviors of their parents. And, parenting styles can be arrayed on a continuum from nurturing to abusive. The nurturing style promotes child health and builds

> " . . . strong character and a sense of self worth . . . ." while " . . . abusive parenting processes such as hitting, belittling, neglecting basic needs . . . lower an individual's sense of self-worth [and] have a negative impact on the health of the child" (Bavolek, 2000:2).

Again drawing on prior research, Bavolek noted that parenting education, especially for adults and adolescents before they become parents, has been identified

as the most likely strategy to prevent abuse and neglect. The next important piece in program development came from research that showed how abusive parents differed from non-abusive parents. Identification of the problem behaviors is a necessary step in promoting change. As the author pointed out, the identification of these behaviors " . . . is critical to developing effective programs and strategies to assess, treat, and prevent abusive parenting practices" (p. 4). Research results again provided useful guidance. The following constructs emerged:

- *Inappropriate parental expectations of the child*: Abusive parents tend to have unrealistic expectations of child's developmental skills level. They demand that children behave in ways that are developmentally inappropriate for their ages. This stems from lack of knowledge about the capabilities and needs of children at each stage and causes the child stress and a sense of inadequacy, anxiety, impulsivity, poor affect regulation and hyperactivity.
- *Lack of empathy toward child's needs*: Abusive parents are not empathically aware of child's needs or appropriately responsive to them. Abusive parents often do not attend to children because they do not want to "spoil" them, which may leave basic needs unattended. They place a high value on children "being good."
- *Parental value of physical punishment*. Abusive parents have a strong belief in the value of physical punishment. Even babies "should not be given in to," or "allowed to get away with anything." Research has specifically shown that physical punishment increases the probability of deviant behavior, delinquency, and violence in adolescence and adulthood.
- *Parental role reversal:* Abusive parents expect children to be sensitive to parents' needs and responsible for parents' happiness. This is the helpless parent who looks to the child to provide care and comfort.

Having identified problem behaviors as targets for change, program development was further guided by theory: (1) A family is a system. To bring about change, all members must participate; (2) Empathy is the most important characteristic of nurturing parenting; (3) Healthy interactions among family members is the key to reducing family violence; (4) Both cognitive and affective components must be included for learning to be effective.

Most participants were court-ordered or required to attend by social services agencies. Participant groups varied and included families identified as at-risk for abuse and neglect, families in recovery for alcohol or drug abuse, families at risk for delinquency, incarcerated parents, and foster parents. The programs were established for prenatal families, families with preschool children, or pre-teens, or teens, and various ethnic groups. Special adaptations were made for ethnic groups and consistency with ethnic values and language.

The program itself included weekly group sessions held in some convenient location and weekly sessions in participants' homes. Parents' groups and children's groups ran concurrently. Groups included 12 to 15 members and two facilitators. A detailed description of the program can be found in Bavolek's report (web address: ojjdp.ncjrs.org/publications/PubResults.asp).

Evaluation of the program involved identifying and measuring key variables. They included parents' and children's attitudes about parenting practices, parents' and children's personality characteristics, family interaction patterns, nurturing, and parents' evaluation of the program. A pre-test/post-test design was used with a post-post test follow-up one year later. Results showed positive changes in both parents' and children's attitudes about parenting practices. The one-year follow-up indicated the persistence of the changes. Parents became more empathic, showed more appropriate expectations related to children's developmental stage, and decreased use of corporal punishment. Children showed increased self-awareness and understanding of parents and children's roles and a decrease in support of corporal punishment, changes which also showed persistence at the one-year follow-up. In addition, significant changes in personality characteristics were found for both children and parents and family interaction patterns and nurturing also showed positive change. Parents also gave an overall positive evaluation to the program and retained their positive evaluation one-year later.

The example illustrates social problems as arising from social arrangements. Theory and research identified the problem behaviors as learned within a social context and their relationship to the social problems to be addressed. The intervention program, throughout, was guided by theory and empirical support. The program objectives were designed to address behaviors that the research and theory indicated as targets for change. These were operationalized and measured to determine whether the program was effective. That is, the program was similar to a hypothesis. It was hypothesized that the program would result in changes in specifically identified attitudes, personality characteristics and behaviors. The hypothesis was tested by measuring the variables identified and, as results showed, the empirical results showed the effectiveness of the program both at the close and at the one-year follow-up.

Social problems such as domestic violence and those mentioned at the beginning of this chapter arise and are maintained by social arrangements. Sociological practitioners are uniquely situated to analyze social systems and the multiple levels involved in problematic situations and to take the next step as intervention and change agents.

Summary

In sociological practice a practitioner enters into a working relationship with clients to address social problems, problems arising out of existing social arrangements. The sociological practitioner works with members of a client system to define the specific changes necessary and together they work to construct new arrangements that will solve or at least reduce the impact of the problem. The process involves careful assessment of the situation and the development of objectives and targets for change. Throughout, the process is guided by theory and research findings. Recommendations to clients and change strategies should be based on sound principles that are supported by empirical evidence.

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2
Approaches to Problem Solving

Introduction

The purpose of this chapter is to discuss approaches to problem solving useful to sociological practitioners. First, we will discuss the major aspects of problem solving and steps in problem solving. Then, we will discuss six approaches to problem solving: the social systems approach, the human ecological approach, the life cycle approach, the clinical approach, the social norms approach, and the community based approach. Each approach will include application to real-life problems.

Problems and Problem Solving

Problems develop in people's lives, problems develop in social systems. But first, we ask, what makes some situation or condition a problem? Harris (2002) characterized a "problem" as (1) an opportunity for improvement; (2) the difference between one's current state and a chosen goal; and (3) the recognition of an imperfect present and the belief in the possibility of a better future. To recognize some situation or condition as "a problem" is to perceive that it deviates from some desired or valued state. Sociological practitioners usually recognize some condition as problematic if it impairs the social functioning of individuals, groups, communities or organizations and limits their capacity to meet their needs, realize their values, and perform their social function.

The labeling of some condition as a problem is determined by the context in which it occurs, its boundaries, and by those who experience its consequences. For example, if a group of Pro-Life supporters sitting in the Visitors Gallery of the United States Senate suddenly stood up and began yelling "No abortions, no abortions," they would be removed by the Capitol Police. While it is a constitutional right for citizens to protest, and the public is welcome to visit the Senate when it is in session, the Senate is not an acceptable *context* in which to protest. It violates the rules of the Senate regarding parliamentary procedure and decorum. The behavior also crosses the *boundaries* of respect and civility. The protest

has *consequences* for all persons present – it is diversionary, disruptive, and discourteous. While protest groups, in general, are not social problems, some are, especially when members choose contexts for protesting that they know are likely to be emotional, and where boundary violations lead to unpleasant consequences for all present. An example is the bill passed by the Tennessee Senate in 2006 that requires a 500-foot buffer zone between a funeral, burial, or funeral procession and protestors. A religious cult, Dread Pundet Bluto, believes that God is punishing America for its arrogance and tolerance of gays. The group believes that the best place to express their hate is to picket the funerals of veterans killed in the War on Terror shouting, "Thank God for Dead Soldiers" and "God Hates Fags." Other states are considering a similar bill even though the ACLU claims it violates first amendment rights.

Some types of behavior such as domestic violence and child abuse are not new, but they have become social problems. Social scientists attribute the increase in these behaviors to several factors including better detection and reporting, better public education and prevention, laws and resources for protecting victims, broadening the definition of what constitutes abuse, and an increase in aggression and violence in our society. There are several other factors in addition to context, boundaries, and consequences that help us decide when behavior becomes a social problem. Behavior also becomes a social problem when it adversely affects a growing number of people; when it increasingly consumes more human and financial resources to control it; and when it exceeds our society's capability to prevent it.

We all participate in labeling behavior. We may not consider some behaviors to be a problem until they involve us. For example, you might dismiss the behavior of a driver of an adjacent car who blows his horn, shakes his fist, shouts profanities, and cuts in front of you forcing you, and those behind you, to brake hard, as a person with an anger problem. You shake your head and drive on. However, if the driver also points a gun at you, his behavior is out of context, violates legal boundaries, and has potentially life-threatening consequences. His behavior becomes a social problem. The driver, like an abuser or addict, probably will deny that they have a problem, downplaying how their behavior can have severe consequences for others.

One of the difficulties in determining what is and what is not a social problem is our changing norms. Recent research has shown that young people now are less concerned about society's standards and find less need to heed social norms (Twenge, 2006). Twenge attributes the attitudinal changes toward social norms to society's focus on the individual. For example, depending on the context in which they are used, cellular phones can invade personal space and privacy, and user distraction has been shown to lead to increased response time or non-response in traffic situations and increases the likeliness of collisions by four times. Since November, 2006, 14 states have passed laws prohibiting the use of hand held phones while driving. Other states are considering similar action.

Problem Solving

Problem *solving* is a complex process of thought and analysis and action. As LeGault (2006: 5) observed, problem solving requires " . . . the use of knowledge and reasoning to solve problems and plan and produce favorable outcomes . . . ." It requires critical thinking defined by LeGault (2006: 6) as "a cognitive skill that permits a person to logically investigate a situation . . . in order to make a judgment or decision." The objective of problem solving is to locate the source of the difficulty and eliminate it or reduce it, manage it or prevent its recurrence (Harris, 2002). Many problems, especially social problems that arise and are maintained by many factors, do not lend themselves to reductionist problem solving. And, social problems usually require more than one method for solution and may require more than one attempt at solution.

Problem solving can be challenging, demanding, and may require a major investment of time and other resources. But people often believe that a simple solution exists, a "quick fix" or "magic bullet" that will cure all ills, if we look hard enough for it. In medicine, a magic bullet would be the perfect drug to cure a disease, have no negative side effects, and be available and affordable. Similarly, a magic bullet cure for poverty and homelessness would be a solution that does not require major changes in cultural attitudes and social institutions, could be implemented quickly, and does not require major costs. Solutions are rarely simple because social problems are rarely simple.

The Process of Intervention

Intervention and problem solving proceeds through five functional stages: *assessment, program planning, program implementation, program evaluation, and program follow-up.* The stages are not necessarily discrete nor do they usually move in an orderly progression.

The first stage is assessment. It involves an investigation of the case in order to come to an understanding of the problematic situation and devise an operational definition of the problem. It is important to focus, first, on the presenting problem. Initial questions for study are: What is the presenting problem? Is this appropriate for a sociological practitioner? Who is the client? Why is the client seeking help and why now? What has happened to prompt help-seeking at this time?

The term *presenting problem* as used here refers to the client's statement of the problem as they see it, framed in their own words. It is important to pay careful attention to the client's statement and accept it as their formulation and understanding of "what's wrong." It indicates their definition of the situation, their subjective reality, and at least implies their desired outcome. It is also their point of departure: their interaction with a problematic situation stems from their

understanding of it. Later, it may be useful or necessary to help clients reframe their statement of the problem to achieve change.

It is also important that clients believe that they have been attended to and understood. Their future motivation for work may depend on whether they think they have been correctly understood and that they are being helped to address the problem. Finally, it will be useful to compare the client's formulation of the problem with that of other members of the client system to determine the degree of consensus on "what's wrong." Lack of a shared definition of the problem may contribute to the problem or its maintenance.

A second question that must be addressed during the early stages of assessment is whether or not to take the case. The issues are these: (1) Is this case within the scope of your expertise? (2) Can you work effectively with this client? And (3) Is there any reason why you do not want to take this case?

After completing the initial stage, the practitioner must gather detailed data in order to develop an understanding of the case. Assessment is doing a case study. Guided by the nature of the case and the client system, data gathering may involve using structured or unstructured interviews, focus groups, survey questionnaires, psychometric data, educational records, archival data, and medical data. It may also involve identifying key role-occupants in the case.

The goal of assessment is the construction of a formulation, a theory of the case, and an operational definition of what is to be changed. When the formulation is prepared, it should be presented in discussion with the client(s) for further review, discussion, critique, and revision if necessary. When substantial agreement on the formulation and the objectives has been reached, the client and the practitioner will be ready for the next stage of the process.

The second functional stage in the process is planning the various steps to take to achieve the objectives. This is a process of negotiation between the client(s) and the practitioner. The plan should be detailed and stipulate who will do what, when. Clients and the practitioner develop a contract, actual or implied, for the work to be done.

The program should include statements of objectives. Objectives should be stated in observable, measurable terms. Well-formed objectives should have the following parts:

1. Verb and subject. State the condition to be met. For example:
   To reduce delinquency
   To improve study habits
   To provide case management
   To reduce caloric intake
2. The rate or amount. State how much.
3. The time frame. State when the program will end and when the objective is to be achieved.

Generally, two types of objectives are recognized. *Process Objectives* and *Outcome Objectives*. Process objectives are statements about the program operation or services to be delivered, which, it is presumed, will lead to the desired

results. These are statements of who will do what, when, and with whom. Examples of well formed process objectives are:

1. To provide supervised recreational activities for two hours after school, from October 1, until the end of the school year, for 50 middle school youth living in the housing project.
2. To provide 30 hours of training as youth recreational counselors, between September 1 and 30 to 12 college students for work with middle school youth from the housing project.

Outcome objectives are statements about the short and long-term results of the intervention. Outcome objectives are quantifiable and measured against baseline line data, i.e. data gathered prior to the intervention. An example of an outcome objective may be:

To reduce delinquency of project youth by 25% within one year after termination. The more concrete the statement of the objective, the easier it is to measure.

Program implementation is the third step in the process. The agreed upon steps are carried out according to the plan. *The fourth functional stage is program evaluation*. Evaluation measures the performance of the stated objectives, both process and outcome, to determine whether the plan is being carried out as prescribed, and whether or not it appears to be working. Like all the steps in the process, program evaluation is conducted jointly by the practitioner and the client(s). Clients are in the best position to determine whether their needs are being met. The fifth step is *problem follow-up*. It is important to see an intervention to its completion; however, the real effects of an intervention may not be observable or measurable until months after the intervention is completed. Follow-up is a responsibility of the intervener. Those implementing the intervention may need periodic social support and encouragement to sustain the intervention. The intervener and client should include follow-up expectations in their initial negotiations.

For the purpose of this discussion, the functional stages have been presented as discrete steps in a sequence. However, this is not the way they should or do occur in practice. It is important that program evaluation and measurement be built into the program plan. Evaluation should be ongoing, it should carefully follow the progress of the program's implementation from beginning to end. The program should be monitored continually, to see whether it appears to be going according to plan, and whether it seems to be moving toward the objective. By the same token, both assessment and planning are ongoing. The evaluation data may reveal a need for additional assessment or for modification of the plan, calling for changes in the program.

The functional stages in a case are the application of the scientific method to intervention. Data are gathered, leading to theory construction and the formation of hypotheses, which are tested against actual outcomes. Like all theory, the case formulation is treated as tentative, rather than final and sacrosanct. Data either support or fail to support hypotheses. Results may lead to reformulation and new hypotheses or confirm the validity of the approach.

Roles of the Interventionist

An interventionist comes between points in time, events, or persons, to maintain or alter a condition or prevent or compel an action. Intervention is concerned with bringing about change. An interventionist works with clients to change behavior or social arrangements. Some interventions might be legally mandated or imposed, and clients uncooperative. But for any intervention to succeed, a relationship of trust and mutual expectations must exist between the client and intervener. They must respect each other's humanity and share some common values. Building a working relationship takes time, effective communication, and understanding. Therefore, some intervention may need to be incremental. The outcome of an intervention is determined by the degree to which a client is willing to make changes in their own behavior and in the social arrangements that are causing the problem.

Interventions can be inflexible in design and rigorously administered, especially in the fields of justice and health care, or they can be negotiable and make allowances for a client's autonomy and responsibility. How an intervention is structured and implemented depends on its purpose and intended objective. Some interventions intended to assist clients to make major life style or behavioral changes usually need to be structured and clients given responsibility for tracking their progress toward their objective. On the other hand, educational interventions are often information-oriented, giving clients choices, and accountability is often diffused over a period of time.

Sociological practitioners can assume several different kinds of roles as interventionists.

Sengstock (2001) described an intriguing role for the sociological practitioner as a "system maintenance specialist" in health care. She pointed out that many areas of health care present problems that are resolvable by increased sensitivity to the social and cultural situations of patients, their illness experiences, their social support system, their expectations regarding care, and the type of interactions they experience with staff. Indeed, the complex bureaucracy and its subsystems that characterize health care are often overwhelming to patients and taken for granted by staff. A system maintenance specialist could assist both staff and patients in becoming better observers and communicators to reduce possible disappointments, misunderstandings and conflicts and enhance the quality of health care.

The role of "system maintenance specialist" has some similarities to the role of "health broker" described by Bruhn (1987). A health broker can be involved at various levels of social interaction ranging from the individual, group, organization, community, and social institution. Brokering can involve several roles at once, for example, a brokering situation might be to help decipher commonalities and differences among staff that is producing interpersonal conflict and obstructing progression toward reaching a hospital goal. The broker seeks and gives information and, as such, is a facilitator, counselor, and/or coordinator. The broker is a "neutral," interested, and helpful third party who assists in

overcoming barriers and obstacles, seeks clarification, obtains and conveys information, and works toward accommodation or resolution.

Weber (1991) described a role for sociological practitioners in health promotion based on her work developing a health promotion program for municipal employees in a small city. As Weber noted, the promotion of healthy behaviors in the workplace involves "a combination of educational, organizational, and environmental activities designed to support health conducive behavior within the work setting." Health-conducive behavior differs from disease prevention and involves such things as weight reduction, aerobic exercise, blood pressure monitoring, general health education, nutrition, and stress management. With symbolic interaction as the theoretical base and needs assessments and evaluations as the research tools, the intervention involved work with groups of workers and managers to design and implement a program tailored to the needs of the specific organization. The intervention included organizational changes to produce positive outcomes for both individual employees as well as for the organization.

Three different kinds of roles for sociological practitioners capitalize on the need for guidance regarding diversity and the growing number of immigrants to the United States.

Stephenson (1994), and Friedman and Friedman (1993), described roles for sociological practitioners in "diversity management." The issue takes note of demographic changes in ethnic distribution in the United States and the integration of minority members into organizations to the mutual benefit of the organization and the individual worker. Hoffman (1985) described a role for sociological practitioners as "acculturation specialists" who could ease the transition of refugees, many of whom suffer from stigmas and will encounter service dilemmas. He also discussed a related role of "culture broker" whereby a sociological practitioner can assist in developing resettlement programs that are culturally sensitive to refugees who are unemployed, lonely, and unfamiliar with United States language and customs. Hoffman (1987) showed how Alcoholics Anonymous was adapted to the needs of Cuban refugees who were experiencing problems with alcohol during their immigration experience.

Other roles for sociological practitioners include mediators, arbitrators and advocates. These roles are especially apropos in the current era of corporate mergers, restructuring, reframing, and downsizing organizations, and the heightened anxiety and anger among workers regarding lost pensions, reduced benefits, and outsourcing of jobs. The settings and sponsors of these roles will depend upon the sociologist's professional qualifications and time available for consulting. Some sociological practitioners have obtained additional education and certification as a clinical social worker, mediator, or counselor for example, which is an asset in helping clients with multi-faceted problems. Sociological practice is a field with exceptional future challenges to those sociologists who develop new skills and practice in diverse social and cultural arrangements.

Clients and practitioners will have different expectations of each other's responsibilities and of different interventions in each of these situations. Therefore,

matching clients and their problems with practitioners who are trained to assist in solving them is an essential step leading to a successful intervention.

The Social Systems Approach

There are many approaches to problem solving, depending on the nature of the problem and the people involved in the problem. The approaches we have selected for discussion are appropriate for social problems at different levels of complexity. We turn now to a consideration of the first approach to problem solving.

A systems approach is a framework, a way of looking at social structures, rather than a specific theory of human behavior (Chess & Norlin, 1988). Historically, sociologists have had differing opinions about which level should receive primary attention. Macro-sociologists view the total society as the prime focus, and the behavior of the system and its components as a product of the total system's needs and goals. In other words, the whole determines the actions of its parts (Lenski & Lenski, 1987). At the opposite pole are social behaviorists who advocate focusing on the individual. In their view, the acts of individuals cluster into patterns, and the social system is constructed from these patterns; that is, the whole is the sum of its parts. The systems approach takes the macro view.

Systems Concepts

The most basic concept is *system*. Hall and Fagen (1956) defined system as: "a set of objects together with relationships between the objects and between their attributes." Systems exist within environments, which allows us to characterize systems either as open or as closed. *Open systems* interact with their environments – they exchange material, energy, and information with their environments. *Closed systems* do not.

Open Systems

Open systems have the properties of *wholeness* (Hall & Fagen, 1956) and *non-summativity.* Wholeness refers to the property that, "Every part of a system is so related to its fellow parts that a change in one part will cause a change in all of them and in the total system" (Watzlawick, Beavin, & Jackson, 1967:123). That is, the parts of a system are functionally interrelated and the system functions as a coherent whole, not as individual parts. As such, the system is more than the sum of its parts – it is non-summative – and cannot be understood by even the most careful and thorough analysis of its individual parts. The system must be understood as a whole. For elements to function as a system, they must be connected and in communication with each other. They stand in relationship with each other and exchange activity, information, and material. The key to understanding systems is to understand the nature of the interaction and relationship among the parts and how they function.

Dubos (1968) pointed out that it is tempting to dissect a system in the belief that one can learn about it by examining its individual parts. Yet, he noted, most of the pressing problems of humanity involve situations in which systems must be studied as wholes in all the complexity of their interactions. The system as a whole and its individual parts must be taken into consideration.

Open systems also have the property of *equifinality* with regard to system outcomes. This concept refers to independence from initial states. It means that different conditions can bring about similar outcomes, and that similar initial conditions can produce different outcomes. For example, there are different ways to achieve reduced costs in an organization. The process of the system – the interaction of its parts – is the most important consideration in understanding the nature of the system at any given point in time. Open systems also can be characterized as having a *hierarchical order*. Hierarchy is the vertical organization of a system. A system is a sub-system of a higher system.

Open systems are characterized by *boundaries* – which demarcate the system from its environment. Open systems also are characterized by their attempts to maintain stability or *steady state* through *adaptation*. Adaptation refers to the system's "ability to react to the environment in a way favorable to continued operation of the system" (Hall & Fagen, 1956). The condition of steady state, or stability, refers to a system's continued existence or functioning. Systems never exist in a condition of complete change or complete stability. Steady state occurs when the whole system is in balance, equilibrium or homeostasis. It is a way of describing the health of a system. A healthy system in a steady state is changing and acting, but maintaining a viable interactive relationship with its components and its environment. The system's functioning is adequate to ensure its continued existence (Anderson & Carter, 1990). Open systems are systems with *feedback*; that is, the output of a system is fed back into the system to affect subsequent output positively or negatively.

Open systems receive inputs of information, material, and activity, which are processed by the system for the maintenance of a steady state, and act on the environment with an output of information, material, and activity. The effects of the output are fed back as part of subsequent input. Resources that meet the needs of the system's functioning can be considered one type of input. Outputs reflect activities that assure a continued flow of these resources. Another type of input are things that can be considered potentially harmful and threaten the stability of the system. These inputs must be processed by the system and must be met with an output of adaptive responses that act on the environment to avert the threat. If the threat is not rebuffed effectively, the stability of the system may be disrupted and the system fails to survive.

Closed Systems

Human systems can be arrayed along a continuum according to the nature of their relationship with their external environment. Closed systems attempt to maintain boundaries that are more inflexible to the outside environment, however, if closed systems do not maintain some degree of openness they may fail to survive; even

closed systems are not completely self-sufficient. Hirschhorn (1988) described two such examples, the case of a maximum security prison and, NASA and the crash of the space shuttle Challenger.

Prison X was run as a personal stronghold by a politically powerful warden. Prisoners were compliant and the guards were uneducated and poorly paid. The prison was a closed system. However, as the political and social environment shaping the prison changed outside the prison walls, prisoners became less compliant. Guards became more aggressive. A group of prisoners took over a cell block, set fire to the facilities, raped a guard, and were subdued after 18 hours. The prison leaders were unwilling and unable to manage a boundary through which stakeholders outside the prison, such as prison rights groups, were acknowledged while carrying out the task of running a safe prison. As the warden created a closed prison it also led to a more violent prison. Ultimately the prison was brought under control by a change in the prison administration.

The National Aeronautics and Space Administration's (NASA's) failure to prevent the catastrophic launch of the Challenger highlighted the dilemmas of leader abdication that created an open and closed system at the same time. NASA faced unusual political and technical pressures at that time. Faced with budget cuts and a climate of fiscal austerity, NASA wanted to show that the shuttle was commercially viable. This strategy contradicted reality for aspects of the shuttle system were still in the development phase and problems still plagued the engineers and managers. The presidential commission argued that the decision to launch was due to a "tendency to management isolation." NASA engineers and managers created a closed system unresponsive to information and warnings from outsiders.

Prison X and NASA exhibited similar responses. Leaders turned inward to deny the outside world and created an illusion of their invulnerability. Both organizational leaders used bureaucratic processes to keep anxiety in check; the prison warden relied on paternalism while NASA's leaders gave way to agency grandiosity. In both examples the organizations became irrational and illusionary to the detriment of employees and other workers.

Saying that living systems are closed and autonomous is not saying that these systems are isolated (Morgan, 1997). Rather living systems may be self contained in a way that external events have minimal influence on the system, e.g. a monastery or convent. Sometimes it is not possible to identify a system as closed until one is inside it, for example, when the constraints on one's behavior are made known to a person after they have joined a cult. Closed systems are self-referential in that they interact with projections of themselves. It is for this reason that persons inside a closed system would seek assistance from outsiders to intervene in their environment or relationships.

Characteristics of Social Systems

Social systems exist along a continuum ranging from the microlevel, to the meso, to the macro. An individual can be viewed as a social system at the

microlevel. The mesolevel usually includes groups, families, and organizations. The macrolevel includes social institutions, bureaucracies, societies and cultures. These levels are no longer seen by sociologists as distinct elements; all parts of a social system interact and influence each other at all levels. The action of any element affects all the others and the system as a whole. For example, United States immigration policies are not just problems for states bordering Mexico but immigration has profound effects on social institutions throughout the United States, including political, economic, law enforcement, legal, educational, and health care.

Action (energy) and the organization of action are the prime characteristics of social systems. All social systems have an exchange of activity among persons or groups of persons. The interplay of people in a marriage, in a family, or on the job involves the sending and receiving of activity and/or information, both within a system and between the system and its environment. A system's capacity to act is its power to maintain itself and change (adapt). Its energy derives from many sources including the physical stamina of its members, common values and loyalties among the members, and external resources and challenges. When this energy reinforces and strengthens a system, it is said to be synergistic; that is, individuals and the group or organization interact smoothly and efficiently to reach common goals (Anderson & Carter, 1990).

A viable system must not only have energy, the energy must be organized to fulfill the goals of the system. Organization refers to the ordering of the energies of the component parts that result in a whole. Systems differ in the degree of formality of their organization. Disorganization results when system components do not relate or interact efficiently enough to sustain the system's energy to fulfill goals.

Consider a family as a social system. Figure 2.1 represents the system graphically. A family exists in a social as well as in a physical environment. The family is an open system in that it obtains inputs of information, material, and activity (energy) from the environment for the maintenance of its stability. These resources are used (processed) within the family, and members engage in activity (output to the environment) to try to maintain the flow of resources. The behavior of every individual within the family is related to and dependent upon the behavior of all the others. Each member influences and is influenced by the others. Changes in any one member or in the relationship between any two members, bring about changes in all the others and in the family as a whole.

A family is also composed of subsystems. The relationship between the parents is one such subsystem. The relationship among the siblings is another. Yet another is the relationship of the parents to one of the children. And still another is, for example, the relationship between the father and one of the children. And so on. Martin and O'Connor (1989) observed that a family of five can have 25 subsystems in addition to the core system of all five members. The number of subsystems increases geometrically with family size. If family arrangements are

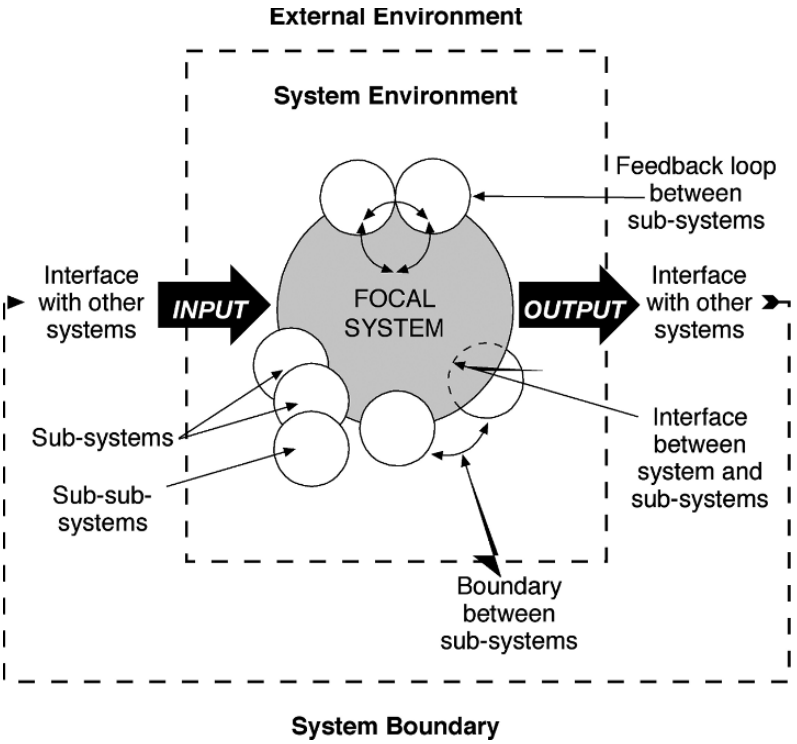

FIGURE 2.1. The Social Systems Model

the problem, the practitioner needs to understand the family system in its totality as well as its subsystems.

> The analysis of a family is not the sum of the analysis of its individual members. There are characteristics of the system, that is, interactional patterns, that transcend the qualities of individual members . . .(Watzlawick et al., 1967:134). Inputs (actions of family members or of the environment) introduced into the family system are acted upon and modified by the system. The nature of the system and its feedback mechanisms must be considered as well as the nature of the input (equifinality). Some families can absorb large reverses and even turn them into rallying points; others seem unable to handle the most insignificant crises. (Watzlawick et al., 1967:139)

Families also attempt to cope with threats to the stability of the family group. Members may be bound together by strong ties, both instrumental and socio-emotional. Stability refers to the maintenance of the family unit, its movement toward goals, and its continuing to meet the needs of individual family members as well as the family system as a whole. A stressful life event, such as the death or divorce of a parent, or the severe illness of one of the income earners, calls forth attempts to adapt and to maintain the boundaries of the family. These attempts may have varying degrees of success or may result in chaos and dissolution.

Application of the Systems Approach

Systemic thinking refers to the process of using the mind to recognize, conceive, and form the coherence of wholeness, to seek the complete picture. The system consists of elements capable of being understood, which cohere to one another. Systemic thinking seeks coherence (Anderson & Carter, 1990).

The systems framework avoids the usual linear cause-effect approach to problem identification by calling attention to the interplay of many factors and system levels as well as to feedback loops. Phenomena are labeled "problems" when they threaten the stable functioning of a social system. Thus, solutions may involve changing actions, the nature of relationships, perceptions, beliefs, norms, or expectations. The systems approach also calls attention to the fact that solutions create new problems, calling for renewed efforts at adaptation, and that stability maintaining mechanisms may exist that will work against change and for maintenance of the present system, no matter how maladaptive it may seem to the practitioner. This is expected of a human system, which is characterized by two general assumptions: 1) the state or conditions of a system, at any one point in time, is a function of the interaction between it and the environment in which it operates; 2) change and conflict are always evident in a system (Longres, 1990).

The systems approach offers general principles applicable to problem solving in social systems. The first principle is to identify, accurately, the system of interest. The concept, *focal system*, is simply the system of interest or study, the one the investigator is focusing on. Depending on the problems, the system of interest may be a department within a county agency, in which case, relations among workers and between workers and the supervisor are subsystems. The environment includes other departments that interact with this department at the same system level. Agency management may be a supra-system, a system level above. County government and its policy and fiscal apparatus may be considered the next step above. The public to be served is also part of the environment. Inputs to this system may be support services from other departments, policy guidelines from management, new resources, legitimization and mission statements from county government, demands from the public for services, or changes in management or hiring practices. Outputs are services, reports, accountability, or products.

On the other hand, the entire agency may be the focal system, in which case, the various departments, as elements of the system, are subsystems. Or, the problem may dictate that the county itself is the focal system with the environment represented by the rest of the state, including other counties, state government, and perhaps other states and federal agencies. In this case, county government, agencies, and residents are subsystems.

Parsons (1951) identified four basic requisites that must be filled in any social system: First, *there is a tendency for social systems to define and attempt to achieve certain objectives*. These may be functional or dysfunctional. Assessment should identify the condition in the focal system. Is it dysfunctional

or disruptive to the functioning of the system, or needs revitalization, improvement? In problem analysis, it is important to consider whether the needs and problems of client systems are a product of the transactions between them and the individuals and groups that make up the environment of the system. It is also important to identify the factors in the system, as well as in the environment that influence its effective functioning. Consideration needs to be given to the identification of resources available within and outside the system that will help to solve the problem.

Secondly, *there is a tendency of social systems to maintain existing patterns and boundaries*. Careful definition of the focal system helps avoid confusion of levels. That is, it helps avoid dealing with system, supra-system, and subsystem problems as though all the problems were of the same kind and at the same level of complexity. The confusion of levels may result in a misidentification of the problem and direct attention away from the most appropriate locus of intervention. For example, a child's behavioral problems may reflect more pervasive and deeper problems in the entire family. The child, however, becomes the "lightning rod" and is brought by parents to a professional for help (Bruhn, 1977).

Third, *most social systems are composed of complex interrelationships and processes*. This includes feedback loops. For example, while rigid authoritarian rules may be a response to rule breaking, they also may cause it. Deviance from the rules may lead to vigorous enforcement, which, in turn, may lead to an acceleration of deviance, which may further increase enforcement. The two may stand in a dialectical relationship. This is not to say that removing authority will solve the problem of rule breaking, but to call attention to the interactive, rather than the linear nature of problems. The practitioner, as the outside observer, needs to recognize and perhaps address the non-linear aspect. Watzlawick et al. (1967:54) pointed out, that what is cause and what is effect depends on the "punctuation of the sequence of events." Actors on different sides of an issue are likely to punctuate events from their own perspectives. Workers may find management harsh and intractable, whereas management finds workers stubborn and unyielding. For the clinician, system thinking points to the relationship, the interaction – how the acts of each element prompt its subsequent interaction within the system.

Fourth, *social systems tend toward a steady state, even though it may be dysfunctional*. The system may have adapted to the disruptive element and developed a stable pattern of functioning that includes it. The tendency of social systems is to try to keep their parts together by countering threats to their steady states. For example, families with an alcoholic or abusive member often develop stable patterns that take the member's behavior into account. Family members modify their role relationships and role performance to adapt to the disruptive effects of the dysfunctional member; in other words, family members may "work around" the problem and become protective of the dysfunctional member. At the other extreme, members of the family may runaway to escape family conflict (See Application 2.1).

APPLICATION 2.1 Social Systems Approach

The social systems approach can be illustrated by a study of 602 runaway and homeless adolescents (Whitbeck & Hoyt, 1999). A life events matrix was constructed for each adolescent enabling the researchers to construct a table of consecutive life transitions beginning at birth and ending with the adolescent's current living situation. The results showed a recurring theme or early independence for children resulting from multiple changes in caretakers and in residence. The more transitions the children experienced in family structure and residence, the earlier they initiated change on their own. Adolescents left homes characterized by loose family ties and multiple transitions. Frequently, problems spanned generations. Adolescents repeated family histories of alcohol and drug problems, mental health problems, and troubles with the law. The family portrait was one of multiply troubled family members, high levels of family conflict, and fragile, temporary family situations. Parent/caretaker alcohol and drug problems resulted in discomfort for the adolescents, diminished parenting skills of caretakers, and increased exposure to violence and abuse. Within families children became increasingly self-sufficient. Leaving home became easy; it meant escaping conflict.

Homelessness is a process of marginalization created by forced early maturation. The greater the family conflict and abuse the more the child separates from the family. The process of leaving separates him/her even more. Once on their own their options change; they transfer their allegiance to nonadults. Same aged social networks have critical developmental consequences; to get by, adaptation involves new survival skills. Results suggested that adolescents carried what they knew into early independence. Maladaptive behaviors learned at home were those used in their new networks. The researchers conclude that family factors may have resulted in early independence, but "too-early adulthood" extracts a heavy developmental price above and beyond the negative family experiences. Runaways are literally learning to become marginalized adults. While shelters exist in some cities, the more challenging problem is how best to intervene to teach healthy resocialization skills to adolescents who escaped from the most significant developmental period of their lives.

In this illustration the family is the focal system, but the subsystems of the family are dysfunctional because of parental unavailability and the lack of functional boundaries, common goals, and inadequate role performance by adults who are limited by the effects of alcohol and drugs. The major theme for dealing with conflict is to escape or lash out in anger and violence. The focal system lacks integrity and cohesiveness and belief in common principles such as respect for persons. Individuals in this dysfunctional social system have learned to survive, not adapt, to life by observing dysfunctional role models over several generations. Input into this system is limited because the key players do not view their behavior as dysfunctional and therefore do not need the

help of outsiders. The output of the system is the young children who do not have the knowledge and skills or assistance to cope with the disruptions to their lives so they leave the system.

Intervention in this social system would involve changing the environment for the runaways, exposing them to healthy adults and peers, through teaching and mentoring helping them to see and practice healthy alternatives to their behavior. This process will take time, patience, reinforcement, and monitoring to keep the runaway interested, motivated, and supported so the appeal of a life of self-sufficiency does not draw them back to the street.

As a practitioner assesses a social system, understanding the existing structures and relationships that maintain the pattern of the present system is essential. Many social systems engage in boundary maintenance. The tightness of boundaries helps to define the "we" and "them" and, therefore, helps to control membership, communication, and adaptation to the larger environment. Systems that do not maintain boundaries may be weakly organized and have difficulties dealing with outsiders. Systems with rigid and carefully maintained boundaries may have histories of conflict with other systems or problems incorporating innovation. Conflict or dysfunction in a system is likely to yield a mixture of positive and negative results, that is identifying conflicts and dysfunction can also have the benefit of bringing positive aspects or strengths of the system to light.

Finally, the tendency to maintain a steady state may result in forces that resist or work against change. While a particular situation may be dysfunctional for some elements of a social system, and even for the system as a whole, it may be functional for certain other elements. The history of race relations in America is an example. While discrimination and racism have not been functional for the targets or the society, some segments of the society have benefited greatly and, thus, resist change. In many social systems, the present pattern is beneficial in that it is predictable to the members, who have made their own accommodations. Change can threaten their predictive base; though things might not be as good as they could be, the very predictability of the system allows some level of functioning. Change may bring unpredictable results requiring the development of a new accommodation – a step into the unknown. Therefore, elements of social systems may resist or work against change.

The Human Ecology Approach

A variation of the systems approach, the *human ecology approach,* makes use of most of the systems concepts. Human ecology derives from three main sources: plant and animal ecology, geography, and studies of the spatial distribution of social phenomena. The word, "ecology," was first proposed by the German biologist, Ernst Haeckel, in 1869. Usually, ecology is defined as the study of the relationship

of organisms or groups of organisms to their environment. Biologists and sociologists share an interest in the "web of life," in which living things are bound together in a system of interlinked and interdependent lives. The term, "human ecology," was introduced in 1921 by two sociologists of the University of Chicago School of Human Ecology, Robert Park and Ernest Burgess. They were concerned with spatial relationships and the struggle for space, independence, and the division of labor. Of particular interest to social scientists is how an ecological system maintains its wholeness and viability when confronted by forces of change.

A key concept in ecology is the *ecosystem,* which is concerned with the "self nourishing" and "other nourishing" aspects of an interrelationship. When interaction or exchange between internal and external forces is impeded or altered, the stability or viability of the relationship is upset. Therefore, social and biological systems attempt to maintain balance, or homeostasis, or a steady state. This is an ideal situation, which may be realized only temporarily when all aspects of the system are in balance. Due to the constant forces of change that act on systems, they usually are attempting to achieve balance between elements within systems as well as between systems and their environments. How social systems respond to insults and return to their "normal" or natural states following intervention – the process of adaptation – is of interest to sociological practitioners involved in problem solving. It is of particular interest to know what "normality" is for a client system, and assist in movement toward or restoration of a steady state when the system becomes dysfunctional or out of balance.

Characteristics of Ecological Systems

The ecological approach draws attention to the concept of levels of organization as shown in Figure 2.2. The major levels of social organization, individual, group, social institution, community, and society are shown at the left in Figure 2.2. Each of these system levels is an incremental increase in complexity. No level can completely explain the phenomena occurring at that level since all levels are interrelated. For example, an individual cannot be fully understood by an analysis of the individual alone; individuals are influenced by all other levels. The right side of Figure 2.2 indicates the key components of any system. All of these components are involved in the functioning of all various levels of organization.

It is well known that problem solvers usually intervene at only one level of an organization, such as the individual or group level. Since each level explains only part of a system, responses at a higher level of organization (e.g. community) cannot be predicted from the behavior of a lower level (e.g. individual). Indeed, while one system level may be selected for intensive study, explanations based on information gathered at only one level cannot be expected to be sufficient. For example, Heise (1998) used an ecological model to explain the more complex etiology of gender-based violence. She wrote that because male dominance and gender hierarchy do not explain why all men don't beat and rape women, an ecological framework is needed to conceptualize violence as a multifaceted phenomenon grounded in an interplay among personal, situational, and social-cultural factors.

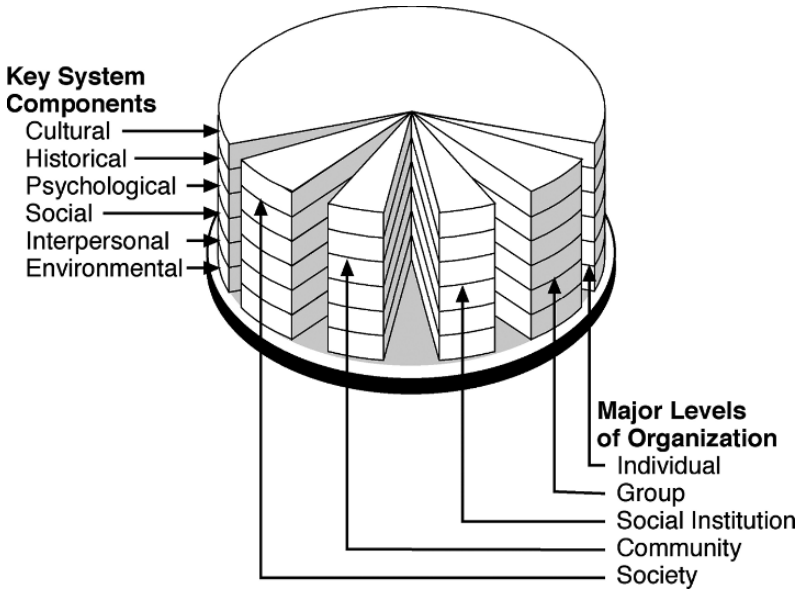

Figure 2.2. The Human Ecology Model: A "Layer Cake" Analogy

This will help practitioners understand real life and complex reasons why couple violence occurs.

Sanders (1994) pointed out that, for years, sociologists have attempted to understand gangs as social organizations. He stated that to understand the phenomena of gangs, we need to examine the situation(s) that precipitate gang violence. Gang activities and gang organization mutually define each other. Both exist in the larger context of certain types of communities. This larger context generates a set of experiences that are handled with resources, language, ideologies, and folklore, which are available to the individuals who live there. The gang is grounded in community realities. Instead of seeking to discover the source of delinquent values, we should attempt to determine how common values are grounded in the experience of community members.

Mexican American gangs are best understood in terms of the barrio and the family. The gang members have a highly romanticized definition of themselves in terms of the barrio, which they protect, and the Chicano culture and history of which they see themselves to be an integral part. The organization of the Mexican-American gang is an extension of the barrio/family ideal of close ties and caring for those who live in the same neighborhood. The gang's primary orientation is sociability; violence, at any given time, is determined by the leadership. Sanders noted, since most of the work done by police is reactive, unless gangs act criminally, the options of the police are limited.

Too often, we view the community or individual as the victim and the police as the problem solvers of gang violence. Our perspectives, analyses, and solutions to the problem of gang violence remain largely reactive and are focused on one

level of organizational analysis (law enforcement). An ecological approach to understanding and intervention requires analysis of the various levels of social organization to learn how and why gangs attract and retain members, and what conditions are conducive to nonviolent as well as violent behavior. Not all gang behavior is negative. Therefore, it is necessary to examine different gang cultures to understand their purpose, activities, and goals.

Activities that are defined as problems are conceptualized as upsetting to the balance or steady state of the system. Problem solving and intervention place emphasis on restoring the balance of the entire system. The task of the problem solver is to learn how a system operates, especially what forces or conditions help it to function in the desired manner, and help to bring about this result. Indeed, it would be difficult to introduce an intervention or change in one segment of an ecological system without affecting all other parts of the system. The challenge is to learn what facilitates and what inhibits balance in the system, with the intention not of eliminating impediments, but of minimizing or controlling them, so that the system can be enhanced and function in the preferred way.

Person-Environment (Ecological) Fit

Stern (1964) expressed the view that people are not randomly distributed among various environments. Their choice appears to be based on the congruence between personal needs and "environmental press," conditions that impede or facilitate the expression of a need and its fulfillment. High levels of performance, satisfaction, and minimal stress indicate a match or "fit" of an individual to the environment. The lack of fit often results in decreased performance, dissatisfaction, and stress. This is not to suggest that everyone in an environment or situation is alike or behaves in the same way, but that most behavior is compatible with the setting in which it occurs. When we see someone acting inappropriately in a setting, we often make inferences about their actions, label them, and limit their freedom.

Fein (1993) pointed out that anger is a common emotion concerned with protecting oneself. Anger can be creative and motivating if used competently. When anger is uncontrolled, excessive, and chronic, it can be a symptom of person-environment misfit. Assessing person-environment fit goes beyond understanding specified roles in different settings, it also includes an in depth analysis of the interpersonal dynamics of role transactions and the effects of changes in the culture of a given setting on specific roles. Individuals frequently express their degree of satisfaction with their "role fit" in different settings through their emotions, especially anger.

The processes that mediate the congruence between actions and the environment are of great importance to practitioners and other problem solvers. The study of a setting may provide answers to some critical questions. Why, for instance, do predictable, regular patterns of behavior occur within the boundaries of the setting? What experiences lead people to change their behaviors as they go from one setting to another? How is it possible for people to behave appropriately when they enter unfamiliar settings?

People behave in ways that are congruent with the immediate setting because they have learned to do so through trial and feedback. People are able to get positive reinforcement and avoid punishment by attending to environmental cues that signal what consequences will follow a given act. Observation of models and responses to behavior in specific social settings also helps people to choose or refrain from choosing certain behaviors. The social settings themselves provide clues that help people determine what is and what is not acceptable behavior. For example, behavior that is acceptable at a football game is not acceptable in a classroom.

As people experience a variety of environments and the behaviors that occur in them, they develop preferences for particular responses to particular settings. They may also limit or restrict themselves to settings that best fit their personalities and needs. Behavioral congruence is learned. It can readily be observed by watching adults model and teach children how to behave in new environments.

Application of the Human Ecological Approach

People enter settings that are likely to promote or enhance their goals and try to avoid settings that do not. They obtain satisfaction from the settings they occupy and actively seek to remain in those settings. When disruption occurs, some take steps to eliminate the disruption. People tend to maintain stability and familiarity in those environments that meet their needs. They shape their settings to attract others who fit them. This permits them to provide continuity and to control change in settings that best meet their collective needs. Therefore, when assessing a problem and considering options for reaching solutions with clients, it is important to determine the fit between the person and the environment.

Various levels of organization, as shown in Figure 2.2, are flexible social units that change and adapt in response to a dynamic environment. Van Valen (1973) proposed the Red Queen Paradox as a way of conceptualizing the dynamic aspect of adaptation. In Lewis Carroll's *Alice Through the Looking Glass,* the Red Queen tells Alice that, even though they are running at top speed, they should not expect to get anywhere. Inhabitants of Looking Glass Land are obliged to run as fast as they can just to stay where they are. To get anywhere, they would have to run ever so much faster. Social units face the same dilemma. The Red Queen Paradox suggests that social units must not only cope with current change, they must continue to refine their coping skills in order to stay where they are. Thus, adaptation and the maintenance of a steady state means coping, with present circumstances and anticipating the effects of future change.

Like the systems approach, the ecological approach calls attention to the interplay of system levels. This approach also draws attention to the complex interactions, or systemic relationships, of the component parts of a social system that make it function as a coordinated whole. *Ecological problem solving requires consideration of the whole and of its parts.* For example, to fully understand the cumulative risk for antisocial behavior among youth it is important to consider both risk factors and protective factors at various ecological levels in a community (See Application 2.2).

APPLICATION 2.2 The Human Ecology Approach

Bogenschneider, Small, and Riley (1994) reviewed current research on risk factors and protective factors that influence the well being of youth. To reduce the incidence of problem behaviors among youth requires addressing risk factors at multiple levels of the child's ecology. Piecemeal, "band aid" approaches that focus on a single risk factor have not worked in preventing youth's vulnerabilities. Even in the face of overwhelming odds, some youth show remarkable resilience and do not encounter problems. The authors examined risk factors and protective factors for anti-social behavior among youth at various ecological levels: individual, family, peer, school, work, and community to understand the cumulative risk for any youth.

Individual Level

Risk Factors	*Protective Factors*
*antisocial behavior (aggressiveness)	*well-developed problem solving skills and intellectual abilities
*alienation or rebelliousness	*a sense of self esteem, self efficacy and personal responsibility
*early initiation to drugs, sex, etc.	*well-developed social and interpersonal skills
	*religious commitment

Family Level

*poor parental monitoring	*a close positive relationship with at least one person
*distant, uninvolved, inconsistent parenting	
*unclear family rules, expectations and rewards	

Peer Level

*association with peers engaged in similar behaviors	*resilience

School Level

*school transitions, academic failure,	*positive school experiences low commitment to school

Work Setting Level

*long hours	*productive roles in household

Community Level

*low socioeconomic status	*belonging to a supportive community

*complacency or permissive laws, norms
*low neighborhood attachment
*community disorganization
*high geographical mobility
*media influence

*bonding to social institutions, school and family

An ecological risk-focused approach to understanding and preventing youth problem behaviors are multiply determined. The more risk factors subsume protective factors the greater the likelihood that problems will occur. An ecological, risk-focused model of prevention suggests that communities need to address drug and alcohol abuse, and other problems using a comprehensive, multi-dimensional approach. Parent education can address poor family management, schools can take steps to encourage student commitment and involvement. Programs at the individual level can help students cope with negative peer pressure. Not every risk factor has the same weight and may not need to be addressed. In some communities strengthening norms and laws against certain behaviors may be more important than other types of intervention efforts. What is key in the ecological approach is the interrelationships between levels of social organization as well as the total cumulative effects of the risks.

Youth cannot be considered separately from the environments in which they live, work, play, and learn. Youth cannot be educated or changed without regard for the social context that surrounds them and molds them.

Several other principles emerge from the ecological approach. Since individuals and social groupings have established histories of adaptation, it is useful to identify the factors that enable adaptation and/or threaten equilibrium. A longitudinal or historical perspective often is valuable in identifying causal relationships to problems. Comparisons between the same or similar levels of social organization in similar environments and time periods also can be enlightening. These comparisons can be useful in identifying anomalies or traces of the past that have lingered despite a changed environment.

The concept of *niche* also can be useful. This place or function that an organism occupies within an ecosystem contributes to its survival and to the total system. The niche defines the role of the individual, group, or other social unit. It indicates what the unit is doing, not just what it is expected to do. Understanding the niche also places the social unit of study in an environmental context. For the practitioner, understanding the niche requires an analysis of the conditions under which it exists, its "fit" in the environment, and how it relates to other components of a larger social system. In this way, the problem solver can identify niche isolation, niche overlap, or a fundamental niche.

Milgram (1977) discussed the importance of psychological maps for adaptation to living in large social systems, such as large cities. These maps are not only

individual products, but are shaped by social and cultural factors. Psychological maps help to define cognitive and emotional boundaries that are critical in controlling overload, i.e. the system's inability to process inputs from the environment because there are too many inputs to cope with. Milgram (1970) listed several responses to system overload that apply equally well to individuals, groups, organizations, and other social groupings:

1. Less time given to each input (limit time and involvement with new inputs).
2. Disregard low priority inputs (the investment of time and energy are reserved for carefully defined inputs).
3. Redrawing of boundaries in certain social transactions to shift the burden of the overloaded system to another party in the exchange (bus drivers once made change for riders, now the responsibility for having the right change has been shifted to the customer).
4. Blocking off reception prior to entering a system (use of unlisted telephone numbers; not answering the telephone or taking it off the hook).
5. Diminishing the intensity of inputs with filtering devices (only become superficially involved).
6. Creating specialized institutions to absorb inputs that would otherwise overwhelm the individual (welfare departments, social security departments and other special agencies).

Application of the cognitive map concept to gain insight into the different perceptions held by members of cultural, age or other sub-groups is relevant to many current social issues. In many social systems, the violation of norms is covert and cannot easily be observed. The cognitive map can be applied to families, social institutions, and small communities to verify perceptions, clarify role behavior, identify the limits of social responsibility, and understand the norms of anonymity and non-involvement. Milgram's approach could be used by the practitioner to identify ecological supports. Milgram, Liberty, Toledo, and Wackenhut (1986) noted that any social system requires a means of defense to protect its integrity. Sociological practitioners will be faced with many clients whose integrity has been violated or whose identity has been threatened.

One classic example of the ecological "web of life" principle can be seen in the paintings of the great wildlife artist, Audubon. He never painted birds flying against a blue sky. They were always perched in a tree or bush or weeds. But the choice of tree was far from accidental; each bird was perched in an essential part of its habitat, in a tree that it feeds from or nests in, sometimes even a tree whose seeds are spread by the bird. Indeed, in many cases, the bird is found only where the tree is also found, and vice versa. Audubon made this insight a part of each painting: that while the bird and tree are separate species, they are in some fundamental sense also a system. Save the tree and the bird is saved; destroy the tree and the bird is also destroyed. The same is true of humans and their social habitats (Bogenschneider, 1994:16–17).

The Life Cycle Approach

The course of life unfolds, not as a steady stream, but in stages. Age, time, rites of passage, and social circumstances are major considerations in the study of the life cycle. Researchers and theorists may classify time periods differently, may stress different kinds of events, or may believe that one influence is of greater significance than others. Most would agree, however, that over the course of a lifetime, individuals pass through various developmental stages and experience critical events that require coping and adaptation. Viewed another way, the study of the life cycle is the study of development, which begins at birth and ends with death.

Despite the uniqueness of individuals and the different cultures and environments in which they are reared, all persons have several aspects of life in common:

1. they have a limited life span;
2. they have similar biological needs;
3. their lives go through a cycle of maturation, maturity, decline and death;
4. they need to learn to adapt and to become integrated persons;
5. they are dependent upon others to help provide an environment and society in which to live;
6. they must experience change (Lidz, 1968).

Development means change. As people move from one developmental stage to the next, they need to adapt to the changes, challenges, and demands of each stage, and to integrate the changes. Thus, in adolescence, people are faced, among other things, with rapid changes in their bodies that must be coped with and integrated into self. Erikson (1963) observed that the way the challenges and demands of one stage are resolved sets the stage for the approach to and resolution of the challenges and demands of the next stage. Each individual meets developmental issues differently, and individuals often repeat the pattern of behavior with which they handle various life crises.

Developmental Theories and Concepts

Several theorists have addressed the life cycle. Sigmund Freud (1962) noted five phases of psychosexual development between birth and maturity. Freud's stages were used, in a broader sense, to draw attention to important aspects of child development and parent-child interaction. Harry Stack Sullivan (1953) and Erik Erikson (1963) formulated modifications of Freud's developmental theory. Sullivan postulated the importance of interpersonal transactions between parent and child and the child's development in a social system. Erikson superimposed critical psychosocial tasks upon Freud's psychosexual stages, stating that certain psychosocial tasks needed to be completed at each of eight stages to prepare an individual to move to the next stage. Erikson's formulations emphasized that "Every psychosocial crisis reflects some discrepancy between the developmental competencies of the person at the beginning of the stage and the societal pressures for more effective

integrated functioning." Thus, "certain kinds of psychological work and certain kinds of social interaction appear to be necessary in order for a person to continue to grow at each life stage" (Newman & Newman, 1984:34).

Jean Piaget (1952) divided cognitive development into four major periods, which, in turn, were subdivided into stages and substages. He dealt, in detail, with the problems of logic, thought, and philosophy, stressing invention, creativity, and the ability of the person to grow. Piaget stressed the importance of the continuing interaction between the person and the environment. Lawrence Kohlberg (1981) applied Piaget's theory to the development of moral judgments. Kohlberg identified six stages, centering upon increasingly wider social systems in making moral judgments.

Robert Havinghurst (1972) proposed a theory of development that was based on the concept of developmental tasks. He believed that development is achieved as a person learns and successfully completes each of a series of specific age-related tasks in six general categories. Abraham Maslow (1968) believed that human beings aspired to become self-actualized. He considered human potential as vastly underestimated. His theory of self-actualization was based on a hierarchy of needs. He illustrated his theory with a triangle where basic needs formed the base, growth needs formed the middle, and self-actualization was the apex of the triangle. Maslow believed that only a small minority of people reach their full potential as human beings. Some individuals are growth motivated while others seem satisfied to meet their basic needs. Growth motivated individuals can fulfill their own needs and simultaneously achieve a selflessness so that the self and the world are no longer different. Through the fusion of the inner and outer world the individual reaches a stage of self-actualization (Anderson & Carter, 1990; Lidz, 1968; Longres, 1990).

Across these theoretical approaches to the life cycle, two concepts stand out: *transitions and individuality* (Spierer, 1977). Lidz (1968) identified three major options as one moves along the life course: progression, fixation, or regression. The ability to cope successfully with challenge and change prevents stagnation and regression.

Life Cycle Transitions and Life Patterns: Transitions within a life cycle can be defined in three ways: (1) by time periods within the life span, (2) by role changes, or (3) by event (Spierer, 1977). Age may be an important factor in most transitions, but it is often difficult to find societal consensus about ages at which specific life transitions should occur. The age at first marriage, the age at first job, the age at which puberty begins, and the age for bearing the first child vary from group to group and vary over time. Changes in social norms change expectations about the time at which certain life transitions should occur. Societal responses to teenage marriages and motherhood, and opinions about what should be the legal age for purchasing alcoholic beverages are examples. Chronological age is only one aspect to consider in regard to life transitions. Psychological age, social age, and functional age all influence the ability of an individual to assume new role responsibilities and to cope with new life events. From the practitioner's point of view, how individuals, groups, or organizations coped with past life transitions, and how their experiences with life transitions compare with the experiences expected by critical others, is of particular interest.

Families also progress through stages of development and experience critical transitions. The most frequently used set of developmental stages of family life was developed by Duvall (1977), who identified eight stages. Success in one stage made for success in later stages. Hill (1970) emphasized three generational aspects of the life cycle. His view is that each stage constitutes a complex distinction of generational roles among family members.

Most family development research has focused on descriptions of the family within specific stages, but information on the developmental processes still is scarce. Researchers differ in their views regarding whether equilibrium or structural change is more characteristic of families over time. The concept of "ease of role transition," from stage to stage, was created to account for variability among families (Mederer & Hill, 1983). However, the recognition of particular stages allows one to concentrate on the changes and adaptations in role relations, reciprocities, and role conflicts at different periods in a family's development.

Stages of group development also have been recognized by various researchers and social theorists (Bales, 1950; Tuckman, 1965; Tuckman & Jensen, 1977). In general, these formulations recognize that newly formed groups have a "natural history." They must complete certain developmental tasks as they move toward accomplishing the work of the group. Developing groups need to arrive at a stable structure of roles and relationships as they progress toward task performance and accomplishment. Knowledge of the various stages, and assessment of the particular stage in which a group is involved, fosters understanding of the challenges facing the group and of their developmental trajectory.

In focusing on life cycle stages, we have noted some common themes. One theme is that development and change must be experienced and integrated in some way. Another is that tasks or challenges are confronted at various stages of development. The accomplishment of these tasks or resolution of these challenges is summative in that coping at one stage is influenced by resolutions arrived at in the previous stage. Underlying these themes is the idea that individuals, families, groups, and organizations maintain both continuity and change.

Continuity and Change: Although the main theme of the life cycle approach is change, it emphasizes the continuity of life as well. Individuals and social groupings develop and change over time, face, and attempt to cope with new challenges in each of the various stages of development. Their course is molded by their resolution of the challenges and conflicts at each stage. There is continuity in their movement, and they maintain their identity.

These themes are reflected in the work of Daniel Levinson, Darrow, Klein, Levinson, and McGee (1978) who used biographical interviews with 40 North American men, aged 35 to 45, to study life periods and transitions. Within each of these periods or "seasons of a man's life"–childhood, adolescence, early, middle, and later adulthood–Levinson noted stable periods of development that overlapped transitional periods. In the transitional periods, the men evaluated their positions in life and explored new options. The core of Levinson's theory was life structure, that is, there is a basic pattern to a person's life which evolves through an orderly series of universal stages. These stages alternate between periods of

tranquility and transition. During periods of stability a person builds life structure around decisions made in previous stages. Levinson believed transitional periods were inevitable. Choices made were always imperfect so individuals continually experience regrets and a desire for change.

Fiske and Chiriboga (1990) used detailed case studies and quantitative data to trace stability and change in 216 middle class adults as they negotiated late adolescence, young adulthood, early middle age, and later middle age. Over a period of twelve years, they explored the role of stress on personal functioning, gender differences in aging, and the effects of self-concept, goals, and values in achieving life satisfaction among their sample. Though stress disrupted continuity, it also served as a catalyst for change. The impact of stress was greater when the sources of continuity were weaker. The key sources of continuity tended to begin to wane during the middle and later years.

Continuity was also evident in a forty-year longitudinal study of 142 persons. Maas and Kuypers (1974) found the lifestyles and personalities of older people to be remarkably similar to their lifestyles and personalities as young adults. They found considerable evidence for regularity in people's progression from one life stage to the next, as well as evidence that people actively participated in shaping and reacting to their environments. As social and technological change causes dramatic shifts in the way we live, we witness a greater blurring of life periods. For example, there now are grandparents in their early forties and parents in their sixties and seventies who are waiting for their children to marry.

Transitions produce anxiety. Coping strategies are ways to reduce stress and make transitions less painful. David Hamburg (1974) observed patients and parents of patients with severe injuries and illnesses, and developed a general model of coping that consists of *tasks* and *strategies* (Spierer, 1977). Tasks are the requirements for adaptation while strategies are the way to accomplish the tasks. Hamburg identified four tasks that persons under stress need to accomplish: contain the distress within tolerable limits, maintain self-esteem, preserve interpersonal relationships, and meet the conditions of a new environment. Multiple strategies are used to accomplish these tasks: form intermediate goals that are achievable, mobilize existing and new sources of social support, and reminisce about happy experiences.

Similarities in coping strategies among patients or their parents led Hamburg to further specify elements of effective coping:

- Regulate the timing and dosage of the acceptance of adversity; recognize that it is a gradual process;
- Deal with one crisis at a time;
- Seek information from various sources on what is needed to adapt;
- Develop realistic expectations for progress;
- Formulate attainable goals;
- Rehearse behavior patterns in safe situations;
- Test behavior in actual situations;
- Evaluate the reaction to this behavior;
- Try more than one approach;
- Make a commitment and prepare a contingency plan as a buffer.

Individuals, families, groups and organizations can learn tasks and strategies to help them cope more effectively. Social support is an important resource for coping (Bruhn & Philips, 1987; Horman, 1989). Life's transitions are less stressful when they are seen as new options and support is provided by an encouraging network of people.

Application of the Life Cycle Approach

The life cycle approach to problem solving offers several unique perspectives. It shows how and why a client or client system is experiencing problems. It provides both a current and a retrospective view of periods of stability and change, used and needed resources, and their effectiveness in maintaining stability and coping with change. The life cycle approach also can be used to contrast the life cycle under review with others in order to determine appropriateness, timeliness, and the fit of life events and transitions. The life cycle approach allows problem solvers and their clients to take stock of the clients' life situations and explore specific future paths. This approach also can provide clients with the motivation and optimism to assume greater responsibility for events and situations within their control.

The so-called "Watermelon Model" (Spierer, 1977), shown in Figure 2.3, provides a framework for integrating knowledge about the human life cycle. The horizontal

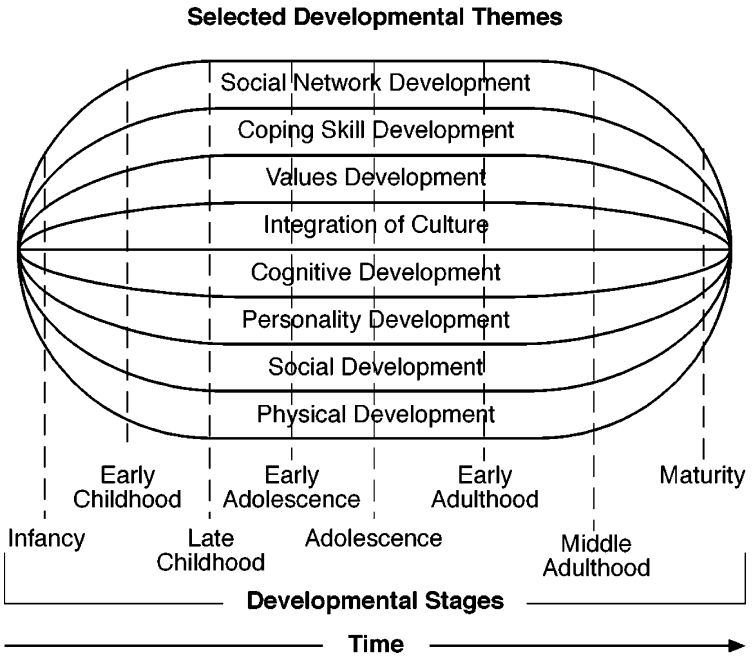

FIGURE 2.3. The Life Cycle Model: A Watermelon Analogy

lines represent processes, and the vertical lines represent critical stages. The third dimension, time, indicates the dynamic aspects of the system. A slice of the melon represents a cross-section of life at a particular point in time. It represents all of the experiences that influenced an individual's life up to that time. This model can be useful to practitioners in problem solving; it provides a holistic way to examine the strengths and weaknesses of an individual, family, or other social unit in a historical perspective. Successes, achievements, and coping styles can be assessed longitudinally to provide the problem solver with factors that may be good predictors of future behavior. The model is flexible, adaptable to different cultures, and additive in its perspective. It emphasizes a life history approach, which focuses on patterns that may have contributed to problems.

Organizations also have life cycles, much like individuals. They are living organisms in a continual process of adapting to their environment and satisfying their needs (Morgan, 1997). The people who are members of the organization are engaged in the same processes; the organization and its members depend upon each other in a symbiotic relationship; as such, they comprise an open system. Organizations continually change. The speed and types of change depend upon each organization's need for input from other organizations in its environment. In addition to these external influences, organizations change internally as they progress through their life cycles. In this sense, organizations like individuals, move through a series of phases or stages of development from birth to death (Bruhn, 2001). Not all organizations die, many are merged or reinvented and therefore may experience life cycle changes more than once. Trust is often the key factor in determining the ease with which an organization moves through its life cycle, how it copes, and whether it survives threats to its viability.

Tichy (1980) has said that organizations do not follow predictable biosocial stages of development because the laws of social systems are not the same as those of biological systems. However, there is agreement that organizations have life cycles and, irrespective of their size and complexity, share some common characteristics as they move from point to point. Quinn and Cameron (1983) found that organizations pass through five life cycle stages. Stage 1 is the *entrepreneurial stage* with an emphasis on marshalling resources, some planning and coordination, forming a niche, and entrepreneurial activities. Stage 2 is the *collectivity stage* in which a sense of mission is developed, innovation continues, there is a high degree of commitment, long hours, and a sense of collectivity. Stage 3 is the *formalization and control stage* in which rules are formalized, the structure is stabilized, institutional procedures are developed, the emphasis is on efficiency and maintenance, and the mode of operation is conservative. Stage 4 is the *elaboration of structure stage* in which the organization undergoes adaptation, renewal, expansion, and decentralization. It has been suggested that there should be a Stage 5, *organizational decline and death*, but death is not inevitable for all organizations.

Problems arise in organizations that are related to their life cycle development. Ouchi (1980) has pointed out that all organizations are in a state of partial failure because new technologies, the rate of change, and the ambiguities of performance

evaluations tend to overwhelm attempts at rational control. In order for leaders to minimize failure and maximize healthiness in their organization, it is important that they be able to understand their organization's life cycle, its demands on members, and sustain a culture that accepts and directs change.

Schein (1992) pointed out that leaders of organizations must become marginal in their own culture if they are to be able to recognize maladaptive behavior. They need to learn new ways of thinking as a prelude to unfreezing and changing their organization. Unfreezing forces can come from the outside or inside by taking advantage of technology, subcultures within the organization, or planned change by leaders. The inability of organizations to adapt to change is at the root of most organizational problems. (See Application 2.3). In Schein's view, in order to prevent stagnation and decline, organizations and their leaders must become perpetual learners.

APPLICATION 2.3 The Life Cycle Approach

Organizations have life cycles and the stages of development in organizations roughly approximates the stages of development in individuals. Kets de Vries (1999) pointed out that organizations, like individuals, share common principles about the process of change. Kets de Vries noted that people possess a pronounced inner resistance to change. Social and psychological investments in the status quo make it difficult to weaken the opposition to change. Indeed, the anxiety and fear about change is sufficient enough to make individuals and organizations preserve dysfunctional patterns of behavior. Kets de Vries found a number of prerequisites of personal change, namely, the crystallization of discontent, the focal event, and the public declaration. Each of these prerequisites plays a role in facilitating change.

The crystallization of discontent refers to some form of discomfort that is usually the catalyst for change. Studies of individual change indicate a high level of stress is a major inducement to change, in other words, stress makes it difficult to maintain the status quo. An accumulation of negative experiences helped to clarify the need for change. This did not come easily or quickly, but gradually preferable alternatives began to crystallize.

The need for change was pushed ahead by some focal event, or the "straw that broke the camel's back." Minor and major focal events are facilitating factors helping an individual or organizational leaders to take the first step. Focal events help individuals acquire an inner strength to make a change. New possibilities are seen as replacing hopelessness.

A public declaration to change is a good indicator of a high degree of commitment to change. Public commitment influences the environment and the speaker by making others aware of a desire to change.

The three prerequisites are accompanied by emotions. As people progress toward making change happen, they give up old roles and identities, reorganize

their world, reevaluate goals, and undergo emotions associated with loss. Individuals and organizations work through the process of giving up and gaining in a succession of phases that may be painful, but if not successfully worked through, can result in frozen feelings that inhibit experiencing the enjoyment of change.

For many people in an organization, change implies a loss of security; they fear the unknown. Insecurity causes anxiety, resulting in the wish to keep old patterns. Other people may fear the uncertainties and new demands and skills that might be required of them. Still others fear the loss of authority or responsibility, and status. Change also threatens alliances and breaks up social networks. Individuals and organizations become stressed and experience degrees of dysfunction related to their ambivalence about change.

While there is "no gain without pain" there needs to be an openness and readiness to share emotions and concerns when change occurs in individuals or organizations. It is the role of parents, peers, leaders and others to provide a safety net of hope and opportunity as the ultimate alternative to not changing. Participation and involvement are key to making real change happen and enabling individuals and organizations to become committed to a new way of doing things.

It is possible to change the mind-set of individuals and organizations if the psychodynamics accompanying change are listened to and attended to. Too often change is a process of trial and error for individuals and organizations. Change is expected and occurs more smoothly when there is a culture of trust and an attitude that encourages people to challenge established ways of doing things. Conflict, in varying degrees, is a part of all change. Conflict can be healthy if leaders understand the dynamics of change.

The Clinical Approach

The clinical approach is a way of evaluating disease, illness, and distress in persons who have sought professional help. It involves three broad perspectives:

1. An assessment of the person as a whole.
2. An assessment of the functioning and state of the components of the body.
3. An assessment of how the person interacts with the external environment.

The clinical approach can be applied, beyond the individual patient, to increasingly complex levels of organization, such as families, groups and communities. Usually the clinical approach attempts to uncover the reason(s) for asynchrony in the system, which creates unpleasant symptoms, dysfunction, or breakdown. This approach also helps in understanding the development of the problem over time, as well as provide insights into possible interventions (See Figure 2.4).

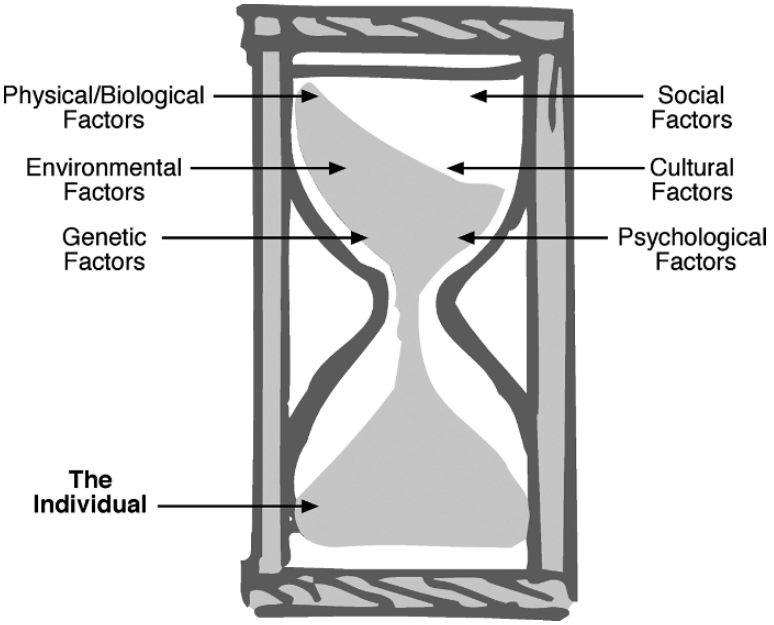

FIGURE 2.4. The Clinical Model: An Hourglass Analogy

The hourglass analogy indicates that the individual system is dynamic and shows how the various components of a living organism flow into making the individual a holistic, changeable, and interactive being.

Problems, whatever their nature, have biological, personal, and environmental connections. Leigh and Reiser (1992) suggested a format, involving these three dimensions, for organizing information from a patient or client. They pointed out that disease is a concept that implies biological dysfunction, while illness refers to the biological dysfunction in a social and cultural context. The Patient Evaluation Grid (PEG) in Table 2.1 shows the interaction of information from these three dimensions similar to the biopsychosocial notion, or behavior in three action systems.

The Patient Evaluation Grid (PEG)

The three dimensions – biological, personal, and environmental – along with three time periods – current, recent, and background – create a nine compartment grid. Each of these compartments can be conceptualized as part of a total system known as "the patient" or "client." Table 2.2 presents the case of a lady who was depressed. There were no biological reasons found to explain her depression. Yet, she was ill and was impaired in her social and psychological functioning. The PEG helps to put her depression in context and to plan how to restore the patient to health.

TABLE 2.1. Patient Evaluation Grid (PEG).

	Contexts		
Dimensions	Current	Recent	Background
Biological	• Physical exam unremarkable • On no medications • No abnormal lab values	• Onset of symptoms began with the diagnosis and impending surgery of only daughter's aneurysm • Daughter is divorced and sole support of two young children	• History of generally good health • Periodic episodes of headaches with situations of stress • Family members in good health
Personal	• Depression, unable to eat, sleep, loss of energy, feeling stressed, angry, worried	• Crying spells, loss of appetite, weight loss, difficulty sleeping, loss of energy, migraine headaches, bleeding ulcers	• Personal habits: compulsive, neat, orderly, punctual, stresses importance of responsibility and loyalty, works hard, perfectionist
Environmental	• Patient lives with husband • Married 25 years • Husband and wife both employed professionals	• Left to care for daughter and her children upon hearing daughter's diagnosis • Husband alone at home and not too self-sufficient	• Lived in same community and worked at same job for past 20 years • Happy marriage • Middle class

The biological dimension covers the person's physical condition, health history, and illness experience. The personal dimension includes personal characteristics, habits, events, behavior, emotions and interpersonal relationships. The environmental dimension is concerned with living and working situations, involvement with the

TABLE 2.2. Illustration of use of Patient Evaluation Grid (PEG).

	Treatment Plans		
Dimensions	Diagnosis	Short term	Long term
Biological	• Depression	• Medication for ulcer • Antidepressant and headache medication and short-term therapy	• Wean from medication • Supportive therapy
Personal	• Stress related to daughter's health and outcome of surgery • Future income and care of two grandchildren • Worry about husband back home	• Obtain part-time assistance in caring for two grandchildren	• Depending on outcome of surgery relocate daughter closer to parents • Involve daughter in self-help group
Environmental	• Change in geographical environment and routine • Absence from job	• Mobilization of relatives and friends to assist husband • Obtain leave of absence from work	• Encourage involvement with support network

community and others, and roles, responsibilities, and relationships of persons in the household. The inclusion of a time dimension permits an analysis of stability and change, and of factors or persons that may be resistant to change. The PEG emphasizes a comprehensive assessment and allows the problem solver to assign priorities to intervention plans.

The clinical approach is not limited to medicine, nor does it necessitate a narrow, disease-centered focus. How the clinical approach is used depends on the orientation, training and motivation of the user. The nature of the model requires that the problem solver interact in depth with the patient or client, probing and inquiring about change in the life of a person, family, group, organization or community. It calls attention to the themes of different systems and their interaction over time. The PEG provides a blue print for the intervener to better understand the dimensions and depth of a problem.

Table 2.2 illustrates the use of the PEG in planning a short-term and long-term intervention for the patient. The plan involves medication and supportive therapy to deal with the biological aspects of the patient's problem. Short-term personal goals involve obtaining assistance in caring for her grandchildren during her daughter's surgery and recovery. Long-term goals include possibly relocating her daughter and involving her in a self-help group. Environmental goals include a leave of absence from work and mobilization of relatives and friends to assist her husband.

Application of the Clinical Approach

How a client adjusts to or copes with a problem is the product of the problem, the characteristics of the client, and the environmental factors that affect the client. Different problems place varying limitations on a client's functioning. The practitioner is faced with three major tasks. First, an attempt must be made to solve the problem. If a problem cannot be solved, the client should be helped to cope with its chronicity. Second, the problem must be prevented from recurring, and its solution from interfering with the client's functioning. Third, the problem and its management must only minimally disrupt the client's social systems. The clinical approach acknowledges that no problem exists by itself, and that all problems and their solutions are interrelated in an interacting system that involves individuals and their environments.

The clinical approach, in the practice of medicine, involves careful and thorough investigation of a case, leading to a diagnosis. Typically, "diagnosis" refers to attaching the correct label to a problem or disorder. This is particularly important in medicine because correct assignment to a diagnostic category usually points the way to specific therapeutic routines derived from the knowledge base of the field. The treatment is monitored carefully to determine its effectiveness and to be alert to harmful effects and other problems.

The technique of rigorous investigation leading to problem definition, planning and follow-up easily transfers from medical to non-medical problem solving for

sociological practitioners and other non-medical problem solvers. Medical problem solving differs from the non-medical approach in that the medical approach is centered around formulating a diagnosis and treatment, whereas the non-medical approach assesses the presenting problem with the client's help and they jointly come up with a doable intervention. Prescribed treatment programs do not exist for most problems dealt with by sociological practitioners. Like the medical practitioner, the sociological practitioner has a knowledge base to draw upon; however, solving the problems with which sociological practitioners are confronted involves developing creative strategies to apply to unique sets of circumstances.

The clinical approach can be applied to understanding attention-deficit/hyperactivity disorder (ADHD) in children, adolescents, and adults. This is a chronic behavioral disorder characterized by persistent hyperactivity, impulsivity, and inattention that impairs educational achievement and/or social functioning. Many of these symptoms occur periodically in normal children. However, in children with ADHD they occur frequently and in several settings, at home, at school, when visiting friends, and they interfere with the child's functioning. Symptoms can persist into adulthood. Hyperactive behavior is often associated with other disruptive disorders. ADHD exists in many cultures although the prevalence is high, 3–7% of children aged 4–17 (American Academy of Pediatrics, 2000); and 4.4% in adults ages 18–44 (Kessler et al., 2006) in Western countries. Boys are affected three times more often than girls. It is estimated that about one-third of children with ADHD symptoms will retain them as adults.

There is no consensus on a single cause of ADHD. Studies have implicated the brain, family genetics, low-birth weight, drug, alcohol and smoking behavior among pregnant mothers, and psychosocial adversity as some of the predisposing factors. Concerns have been raised that children, especially active boys, are being over diagnosed with ADHD and therefore are receiving psychostimulants unnecessarily. Because stimulants are also drugs of abuse and because children with ADHD are at increased risk for substance abuse, concerns have been raised about the potential abuse of stimulants by children taking the medication (Surgeon General's Report on Mental Health, 1999).

Since the cause(s) of ADHD is (are) not definitive, it is not possible to prevent these disorders, hence the common intervention is to treat the symptoms. Because ADHD is a complex set of symptoms one mode of treatment is usually insufficient to "manage" them. Psychostimulants are the most widely used and studied intervention. Cognitive-behavior therapy has not been shown to provide clinically important changes in behavior of children with ADHD. Psychoeducation, that is, providing information to parents, children and teachers about ADHD, along with treatment, is considered a helpful intervention. Many researchers have suggested that multimodel treatment used together with multiple psychosocial interventions in multiple settings should be more effective than medication alone. A National Institute of Mental Health Multimodel Treatment Study of ADHD examined three experimental conditions – medication alone, behavioral treatment alone, and a combination of the two. The study compared the effectiveness of these three treatment modes with each other and with standard care provided in the community

(a control group). It was found that the combined treatment resulted in significant improvement compared to the single modality treatments. Such combined treatments could be used for symptoms of disorders that often accompany ADHD, such as conduct disorders, substance abuse, and learning disabilities (Surgeon General's Report on Mental Health, 1999).

Application 2.4 illustrates how childhood obesity, currently a micro-meso problem, is rapidly becoming a precursor to an epidemic of adult obesity in the United States. The fact that, while the behaviors associated with ADHD and obesity are paradoxical, they share several common causes, namely, family genes, parental role models, stress, and environmental stimuli.

APPLICATION 2.4 The Clinical Approach

Obesity is a growing problem among American children. Obesity in early childhood can lead to adult obesity. Obesity has been linked to several diseases in adults, such as heart disease, cancer, and diabetes. Researchers have found that the risk of obesity is higher for those who were obese in adolescence. Parental obesity also doubles the risk for adult obesity (National Center for Health Statistics, 1999).

Treating and preventing obesity is difficult. Causes vary from person to person and are not fully understood. They include genetics, the environment, and behavior. With respect to genetics it has been shown that children with obese parents are more likely to be obese. With respect to the environment, children observe their parents' weight, and their eating and exercise habits.

United States dietary patterns have changed significantly over the past several decades. Overnutrition has replaced undernutrition as the largest nutrition-related problem facing both children and adults. Our culture supports "oversize" through large portions at restaurants. These trends play roles in the increasing rate of obesity, along with decreased physical activity.

Ellyn Satter (1987) believes in the importance of "the feeding relationship" and its implications for obesity. The feeding relationship is the interaction between parents and children around food. Obese children need to learn to listen to internal cues of hunger and appetite. A restrictive diet may make the child feel deprived and neglected, and exacerbate the overeating problem.

Children and adolescents who watch television more are more obese than peers who watch less. In general, the more television they watch, the greater the prevalence of obesity among children. Nearly half of youths aged 12 to 21 are not vigorously active on a regular basis.

Lifestyles and behavior are learned early in life. The influence of parents, peers, and media are key elements in children learning the place of food in their lives. The effects of obesity are cumulative and often subtle, but the current epidemic of diabetes among adults with approximately sixty percent of Americans being overweight is a signal that food is serving other purposes than satisfying the pangs of hunger in our society.

The Social Norms Approach

As the world becomes smaller, problems become larger as more problems cross boundaries. AIDS quickly developed from a micro to a macro problem. Violence, which used to be a meso problem, now influences the daily lives of individuals world-wide. As Dr. Gary Slutkin, an epidemiologist said, "Violence is an infectious disease," (Shute, 2006). Slutkin asked, "Why not approach violence as unhealthy behavior that can be changed, like smoking? The disease-causing agent is not a microbe but a thought." Slutkin founded Chicago's Center for Violence Prevention (Diehl, 2005). Its Cease Fire antiviolence campaign, funded by the Robert Wood Johnson Foundation, is designed to interrupt and change social norms. First he found politicians, police, clergy, and community leaders who were willing to speak out every time there was a shooting in the neighborhood. "You need multiple messengers with the same message," he said. "That's what worked with smoking." Next, he recruited outreach workers who hit the streets and talked to the target group. In Chicago, where violence now accounts for fifty per cent of homicides, Slutkin recruits ex-cons and ex-gang members and sends them to the same street corners where they once got into trouble. The project is called "Cease Fire." The "Cease Fire" interrupters get would-be perpetrators to consider the consequences. When preventive measures fail the interrupters go to hospital emergency rooms and talk to victim's friends, aiming at heading off retaliation. Outreach workers also offer alternatives such as school or job training, through community organizations.

Since 2000 "Cease Fire" has hired about 120 workers in 16 Chicago neighborhoods and 9 outside the city. In one police district, killings declined from 72 in 2001, to 25 in 2004. New Jersey hopes to use the program in two cities. It will be some time before the long term effects of this social norms intervention are known.

The social norms approach has been described as a proactive prevention model. Developed by H. Wesley Perkins and Alan Berkowitz (1986), this approach states that much of our behavior is influenced by incorrect perceptions of how other members of our social group(s) think and act. For example, an individual may overestimate the permissiveness of peer attitudes or behavior with respect to alcohol and other drugs, or underestimate the extent to which peers engage in health enhancing or risk reducing behavior. The social norms approach predicts that overestimations will result in increased problem behavior while underestimations of healthy behaviors discourage individuals from engaging in them. By correcting these misconceptions it is likely that more healthy behaviors will result. Social norms interventions focus on peer influences. By providing individuals with correct information about their peer group, individuals can be induced to change their behavior. This approach has been used extensively in longitudinal interventions to increase safe drinking and abstention. Significant reductions in binge drinking have been associated with the promotion of accurate norms about drinking behavior (Fabrino, McKinney, Hyun, Mertz, & Rhoads, 1999; Haines, 1996; Perkins, 2002; Wechsler et al., 2003).

The University of Arizona combined a universal social norms marketing intervention with a required BASICS (Brief Alcohol Screening and Intervention for College Students) intervention for high-risk drinkers in a successful campaign to promote healthy drinking and abstinence (Johannessen, Collins, Mills-Nouoa, & Glider, 1999). The results of their campaign suggested that it was possible to combine social norms interventions at all levels of prevention to create a comprehensive change environment with mutually-reinforcing, synergistic messages delivered through a variety of channels to a variety of audiences.

Numerous other social norms interventions with respect to alcohol and other drugs can be found at www.edc.org/hec/socialnorms/theory.html. The social norms approach has also been used to reduce prejudicial behavior (Lowery, Hardin & Sinclair, 2001); reduce childhood obesity (Thompson, 2004); and improve academic climate by addressing issues of violence, racism, homophobia, recruitment of students and faculty of color (Council on Campus Climate, 2001; Hernandez & Seem, 2004).

The social norms approach can provide a framework for developing interventions that focus on three levels: universal, selective and indicated. The universal level is directed at all members of a population without identifying those at risk for the problem. The selective level is directed at members of a group who are at risk for the problem behavior. The indicated level is directed at specific individuals who already show signs of the problem. All three levels can be integrated to create a comprehensive intervention.

Application 2.5 discusses how our society's norms about caregiving and caregivers are changing. There is concern that there will be insufficient caregivers to assist the growing number of retired, old-old, and functionally disabled persons in the coming decades. Attitudes and behavior about aging and the aged still carry a stigma and norms regarding men as caregivers still remain very traditional. Asian and many European cultures have positive attitudes and behaviors about growing old that could be models for the United States.

APPLICATION 2.5 The Social Norms Approach

Our aging population, people living longer with disabilities and chronic diseases, and the changing form and purpose of the American family have changed our social norms about caregiving and caregivers. An estimated seven million Americans are taking care of an elderly relative and a disproportionate number of these family caregivers are women. About 45 percent of these caregivers are also employed outside the home. Today, men comprise nearly one-third of all primary caregivers to older adults (Atchley & Barusch, 2004). Gender stereotypes and men's self perceptions create a significant challenges for male caregivers. Traditional male attitudes are a barrier for joining a support group and sharing experiences with other men. As American society

grows older, the need for family caregivers of both genders becomes more acute (National Council on Aging and Pew Charitable Trusts, 1997).

Grandparents are being called on in record numbers to care for their grandchildren. Teenage births, the frequency of single-parent households, the increased numbers of women in prison, drug abuse, random violence, and AIDS are all reasons why mothers are losing their roles as primary caregivers (McKelvy & Drimin, 2002).

Declining birth and death rates have expanded generational layers often referred to as the "beanpole family," which may contain as many as five generations. The multi-generational family has become the norm. The effects of the egalitarian family, increased divorce and remarriage rates, unwed parenthood, and new family forms have raised concerns as years of caregiving are extended and encompass aging ex-parents in law and step-children, in addition to one's own parents.

The Community Based Approach

The community based approach to problem solving is to assist communities to plan, develop, and implement a community based intervention to solve a problem. The rationale is that, if citizens become invested in establishing a structure and process for solving their local problems, they will be more likely to become proactive in preventing future ones.

The community based approach is not new. It has been used in criminal justice reforms such as the "problem solving justice" model in which courts focus on addressing the underlying social problems that strongly correlate with crime. Innovative courts focusing on local citizen involvement and the principles of problem solving justice have proven effective alternatives to conventional courts processing drugs, domestic violence, prostitution, and soliciting for prostitution. The goal is to solve the problems that are driving the caseloads rather than just processing people through the system (Berman & Feinblatt, 2005).

Community policing has become a well-known approach to problem solving. It rests on the belief that the police and community must work as partners to solve local problems. Officers work closely with community organizations to educate community members about community hazards and how to reduce the likelihood of becoming a victim. The goals are to identify the problem and improve the community's safety by giving citizens information about how they can become more responsible for their own safety. There are no prerequisites for becoming a problem solver. You do not have to be a leader, just a good citizen who wants to make a difference.

Etzioni (1993) questioned whether efforts like community policing can shore up communities by themselves or whether community rebuilding needs to be advanced by other means. He asked, "Can community policy, for instance, work in those parts of Los Angeles in which there is little community?" Etzioni concluded

that to rebuild communities we need to draw on community institutions and allow people to apply their civic commitment at the local level.

Lasker and Weiss (2003) describe a community health governance model that lays out the pathways by which broad participatory collaboration processes lead to more effective community problem solving and to improvements in community health. The model proposes that three outcomes are important as communities strengthen their capacities to solve problems: individual empowerment, bridging social ties, and synergy. The growing interest in using collaboration to deal with community health problems stems from the fact that these problems are complex; consequently they go beyond the capacity, resources, or jurisdiction of any single person, program, or organization to change the problem. Problems that require comprehensive actions have been difficult to solve when the needed participants are not present or when constituents work at cross purposes. The advantages of solving problems at the community level are that interventions can:

- build on community assets
- be tailored to local conditions (politics, economy)
- connect to multiple services, programs, and policies more readily
- attack a problem from multiple vantage points simultaneously
- be culturally appropriate
- be observed and monitored directly

Levels of Community Problem Solving

Community problem solving has been effective for several reasons: 1) it enables the parties involved in interventions to have face-to-face interaction; 2) it enables communities to develop the type of communication pattern necessary for solving the problem in their community; and 3) it enables the parties involved to have a vested interest in the entire problem solving process and see the outcome.

Table 2.3 shows some of the different types of communication patterns or connections that are available to give structure to the process of solving problems at a local level. Each of these levels: networking, alliances, partnerships, coalitions, and collaboration has a different purpose, structure, and process. Problem solving can begin at one level and merge into more formal, committed relationships with other organizations, agencies, social institutions, or communities.

Gladwell (2006) wrote that homelessness does not have a normal distribution. It has a power law distribution where all the activity is not in the middle but at one extreme. Gladwell told of a Boston College graduate student, Dennis Culhane, who lived in a shelter in Philadelphia for seven weeks as part of his doctoral dissertation. He found that eighty percent of the homeless were in and out of shelters rather quickly. The next ten percent were episodic users, but it was the last ten percent, the group at the farthest end of the curve, that were chronically homeless, sometimes for years at a time, who were responsible for the majority of health care and social system costs.

TABLE 2.3. Levels of community problem solving.

Levels	Purpose	Structure	Process
Networking	• Dialogue and common understanding • Clearinghouse for information • Create base of support	• Non-hierarchical • Loose/flexible links • Roles loosely defined • Communication is primary link among members	• Low key leadership • Minimal decision making • Little conflict • Informal communication
Alliance	• Match needs and provide coordination • Limit duplication of services • Ensure tasks are done	• Body of people with a common concern • Semi-formal links • Roles informally defined • Links are advisory • Few financial resources	• Facilitative leaders • Shared decision making • Some conflict • Formal communication limited to central group
Partnership	• Share resources to address common issues	• Central body makes decisions • Roles defined • Links formalized • Group leverages/ raises money	• Autonomous leadership but focus is on issue • Group decision making in central and subgroups • Communication is frequent
Coalition	• Share ideas and resources from existing systems • Develop commitment for specified period of time	• All members involved in decision making • Roles and time defined • Written agreements • Group develops new resources and joint budget	• Shared leadership • Decision making involves all members • Communication is prioritized
Collaboration	• Accomplish shared vision and reach common goals • Build interdependent system to address issues and opportunities	• Consensus used in decision making • Roles, time and evaluation formalized • Written work assignments • Shared resources and joint budgets	• Leadership trust level and productivity high • Ideas and decisions openly and equally shared

Adapted from The Chandler Center for Community Leadership, Bend, Oregon, crs.uvm.edu/nnco/Collab/Wellness.html

The leading proponent of "power law theory" is Philip Mangaro who is the Executive Director of the United States Interagency Counsel on Homelessness. Mangaro believed that the homelessness problem at the fringe can be solved. He saw homelessness like the bad cop problem. It's a matter of

a few hard cases. They need time, attention and lots of money. Mangaro has convinced more than 200 cities to reevaluate their policies for dealing with the homeless.

Mangaro believed that first and foremost the chronically homeless need a place to live, along with a support system of caseworkers to help them get on their feet. The idea is that once people become stabilized they will find jobs, and start to pick up more and more of the rent. The challenge, of course, is to stabilize the sickest and most troubled of the homeless. Mangaro said that power law homelessness policy has to do the opposite of normal distribution social policy. "It should create dependency – you want people who have been outside the system to come inside and rebuild their lives under the supervision of caseworkers."

Mangaro stated that there isn't enough money to go around, and to try to help everyone a little bit is not as cost-effective as helping a few people a lot. Soup kitchens and shelters do not solve the problem of homelessness. This is why Mangaro's approach of building interagency coalitions to deal with the high utilization high cost end of the homelessness continuum is both challenging and controversial (see Application 2.6).

APPLICATION 2.6 The Community Based Approach

DIGNITY (Developing Individual Growth and New Independence Through Yourself) is a partnership program of Catholic Charities of Arizona and the City of Phoenix Prosecutor's Office. It is designed to give victims of prostitution the help needed to break away from prostitution and rebuild their lives. DIGNITY programs focus on six areas: 1) Outreach to women on the streets and in the county jail; 2) a 36-hour intensive education and non-traditional case management Diversion Program which is an alternative to incarceration for women arrested for prostitution and a similar program for men who solicit those working in prostitution; 3) a year long transitional program that gives women 18 years and older enough time from the streets to make major life changes; 4) a residential program that focuses on women with health issues due to their lifestyle; 5) an education group is offered two hours weekly in two of the county jails for women seeking to leave prostitution, and 6) staff provide education and training to community groups.

The programs have had over 900 graduates since 1997 with 74 percent of the participants not having any subsequent arrests for prostitution. The programs have saved the City of Phoenix over two million dollars in jail costs alone. Neighborhoods and social services work closely with city and county departments through the City of Phoenix Prostitution Task Force to explore ways to improve the program (Personal communication with Barbara Strachan).

A Decision Tree of the Process of Problem Solving

The various approaches to problem solving share some essential features. All are oriented toward change. All emphasize careful problem assessment. All suggest a multi-factor approach to understanding problems, and to framing their solutions. And all suggest the follow-up and evaluation of positive, negative, intended, and unintended effects. The decision tree in Figure 2.5 offers a practical guide to the identification of key processes in problem solving.

In its elemental form, the decision tree consists of five stages: assessment, program planning, program implementation, program evaluation, and program follow-up. These components can be summarized in four basic questions:

1. What is the presenting problem?
2. Of several options, what is the intervention of choice?
3. Under what conditions can the intervention be most effective?
4. Was the intervention effective?

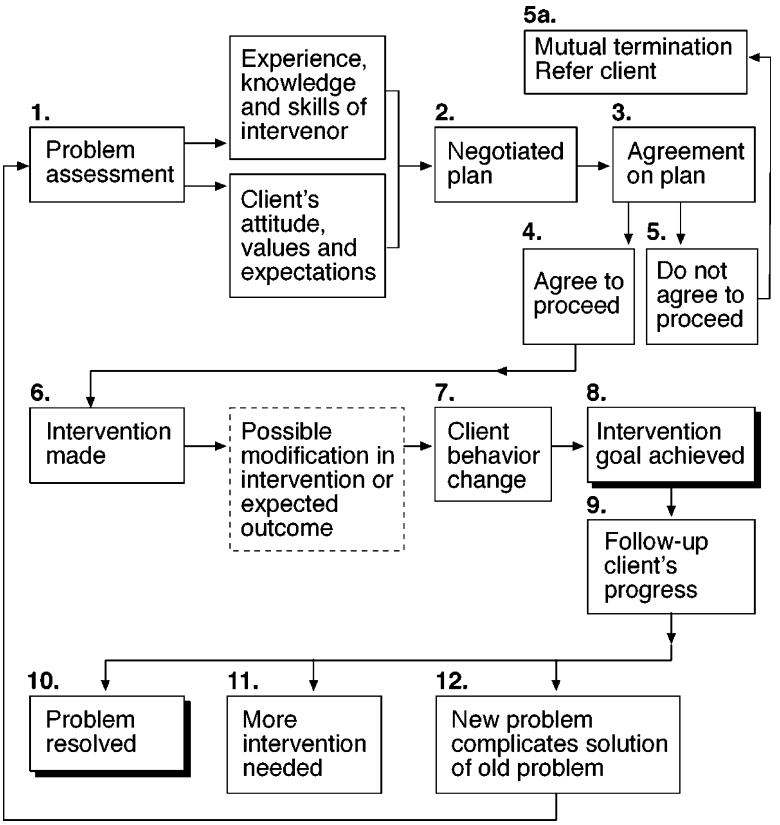

FIGURE 2.5. A Decision Tree of the Process of Problem Solving

Several assumptions are associated with this decision tree: first, that the client and the practitioner have already established rapport and a working alliance; second, that the effectiveness of the techniques and methods cannot be detailed in the model; and third, that one of three endpoints or outcomes will be reached – the goal will be achieved, the client will be referred, or an unresolved or new problem will emerge and the problem solving will recycle. Other outcomes are possible. The client may drop out at any time in the process, or behavioral changes may not be sustained following the intervention, in which case, the intervention must be considered unsuccessful.

The decision tree helps to remind us that the process of problem solving has some degree of order, which can affect its outcome. It also serves to remind the user to involve the client at all steps in problem solving, and to monitor the client and the process. The tree should be useful, irrespective of theoretical orientation.

Summary

All practitioners develop methods of thinking and working toward change, which are embodied in the client systems they work with, their relationship to them, and their techniques for helping with change. Experience helps practitioners mold the models and approaches that they find most useful. Although we emphasize the uniqueness of each situation or case, new situations often are reminiscent of earlier ones and may benefit from a practitioner's experience, calling upon his or her knowledge of what worked well in similar situations, in the past, and might work again.

Six problem solving approaches, summarized in Table 2.4 have been discussed in this chapter. No single approach is superior to another. Most of the approaches can be used in working with individuals, families, groups, organizations, and social institutions. The approaches are analytic; they emphasize interrelationships and boundaries. All are characterized by a need for feedback and an attempt to maintain balance, or equilibrium, or steady state. The life cycle model provides a set of expectations about the future that is based on past events. It has a directional focus and a temporal frame of reference. The clinical model tends to take a "here and now" approach. The social system, ecological, social norms and community based models are applicable to human relations in small or large units. These approaches have the advantage of avoiding simple cause and effect thinking, being useful for identifying loci of intervention, and helping to identify stable and changing aspects of the system.

In problem solving, all professionals, regardless of the model they use, must deal with the reality that change occurs while they are attempting to observe and cope with it. Therefore, in a way, all models are removed from the concreteness of events. Intervention programs do not fall neatly into the models practitioners use. Each practitioner's approach combines experience, skill, risk taking, and "know how."

Problem solving has three main aspects: 1) drawing upon clinical know how, 2) choosing preferable courses of action, and 3) translating professional knowledge and ethics into effective solutions or options. Practice "know how" refers to

TABLE 2.4. Assumptions and interventions in six approaches to problem solving.

Model	Assumptions	Possible interventions for solutions	Usual level of intervention
Social system	• Stability • Change constant and unique	• Unfreezing of beliefs and behavior • Control and guide input and output	• Individual • Family • Organization • Community • Society
Ecologic	• Equilibrium/homeostasis • Interrelatedness	• Confront stresses, strains and tensions • Removal of blockages to collaboration	• Organization • Community • Society
Life cycle	• Continuity • Change	• Build on positive resources and networks	• Individual • Family • Organization
Clinical	• Healthy functioning can be restored	• Change in self (habits, lifestyle) • Removal and amelioration of symptoms	• Individual • Family • Group
Social norms	• Individuals can be induced to change their behavior	• Correcting misperceptions of behavior • Provide correct information about social norms	• Individual • Community • Organization • Society
Community	• Involve members in problem solving • Broad participatory collaborative processes can be effective	• Individual empowerment • Bridging social ties • Synergy	• Individual • Group • Organization • Community

understanding and explaining problematic events. This includes using an assessment, choosing the best approach to working with a difficult client, or choosing an intervention on the basis of its effectiveness. Choosing the preferable course of action sometimes requires considering the risk/benefit ratios of atypical courses of action. Examples include withholding information from a client, or choosing not to use scare treatment resources. Such decisions represent the ethical and value-related aspects of problem solving. Determining whether to pursue an intervention sometimes requires considering values as well as data. Indeed, value conflicts between clients, family members, and practitioners may need to be resolved before any intervention is feasible. The pragmatics of problem solving involve the translation of professional knowledge and ethics into effective solutions or options.

The three aspects of problem solving are present in every problem situation. They may occur simultaneously or separately, but each requires a somewhat different approach, and the situation may require that greater emphasis be placed on one or another aspect. For example, some problems may mainly demand practice "know how", others place equally important demands on the practitioner's

judgment in deciding on alternative plans for implementation, and still others, principally demand the translation of professional knowledge into ethical decision making. Every problem has a theme, which may emphasize different aspects and permutations of the problem situation. All problem solving requires equal consideration of the professional facts, data, and the unique characteristics of the client.

All interventionists must deal with the reality that, irrespective of the problem solving model they use, change occurs while they attempt to observe and cope with it. All models, in a way, are removed from the concreteness of events; interventions do not fall neatly into models. In the final analysis, each practitioner's approach combines personal experience, skill, risk-taking, and "know-how."

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3
Problem Solving at the Microlevel

Introduction

Microlevel sociology focuses on social interactions in specific situations. Observing and talking with children in different ethnic neighborhoods, or the social interactions of sports fans waiting in line to purchase tickets, or how well-dressed people respond to a homeless person on the street, or how a teacher interacts with Native American students in her predominately Caucasian class. Society is a product of the everyday interactions of individuals. It is the shared reality that individuals construct as they interact with one another.

The Individual as a Social Unit

Human life takes place in a social context. Billson (1994:118) noted the inseparability of society and self:

> The cross-fire debate over the relationship between the individual (with all his or her unique qualities) and society (with its capacity for blueprinting that uniqueness) confuses our attempts to understand human behavior. Some disciplines . . . claim to focus on the individual, relegating cultural and societal forces to a nebulous "background."

Cultural and societal forces are *not* background, and, as Billson further observed, "The attempt to separate individual from societal factors has been a thankless and largely fruitless task . . ." engaged in primarily to maintain disciplinary boundaries. In this chapter we offer a sociological perspective on behavior and on work with individuals, families, and small groups.

Sociological practice focuses attention on behaviors that some person or group has defined as problematic. But the sociological perspective teaches that all behavior, problematic or not, arises from similar processes, that these processes are essentially social, and that even the process that results in behaviors being defined as problematic is social as well.

This perspective of behavior is called *biopsychosocial,* recognizing the contribution of three major action systems. Figure 3.1 provides a partial list of influences on behavior under the three major headings.

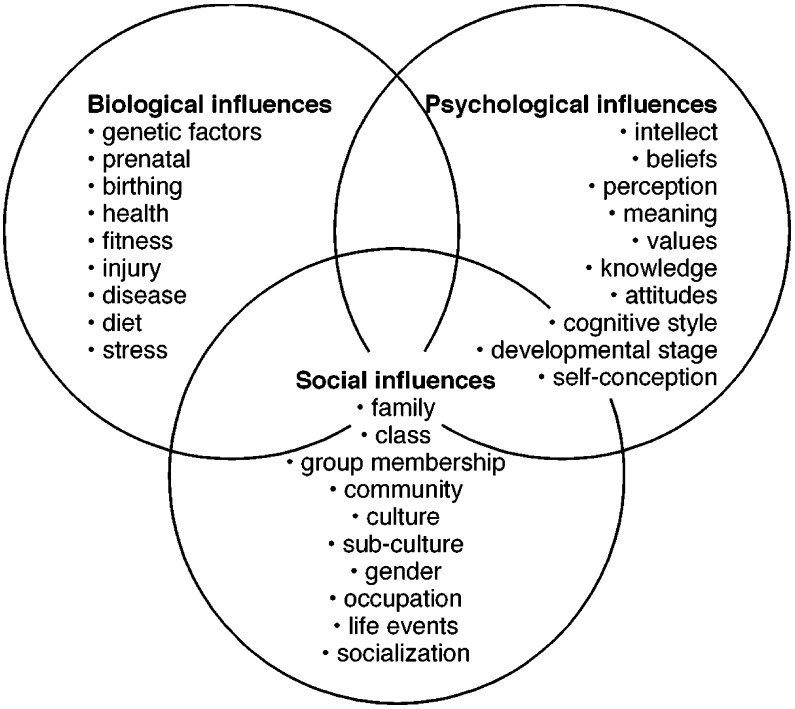

FIGURE 3.1. Influences on Behavior in Three Action Systems

While the lists in the figure are not meant to be exhaustive, they suggest factors under each heading that influence behavior. For example, genetic inheritance is included under biological influences. This includes such obvious factors such as race, size, and looks. To this we must add genetic influences on rate of development; some children are "early bloomers," some are "late bloomers." We must also add disorders that are known to have some genetic component, for example, attention-deficit hyperactivity disorder (ADHD), and genetic predispositions, for example, multiple sclerosis. In general, biological factors set the parameters for what is possible, not in a deterministic sense, but in establishing possibilities or constraints.

In addition to genetics, prenatal events also can have a profound effect on individuals' development. Substance use – alcohol or drugs – by a pregnant woman can have damaging effects on fetal brain development and result in serious impairments of the baby that will last a lifetime. Less evident, but also affecting prenatal development, are issues such as availability of prenatal care, nutrition, health care, and stress on the mother. Diet, health, and fitness are additional biological factors that may affect behavior. Through these factors, social arrangements get translated into the biological development of individuals; poor women are more likely than their more affluent counterparts to lack access to prenatal care, lack nutrition information and resources, and may experience more stressors during pregnancy. It is also likely that factors

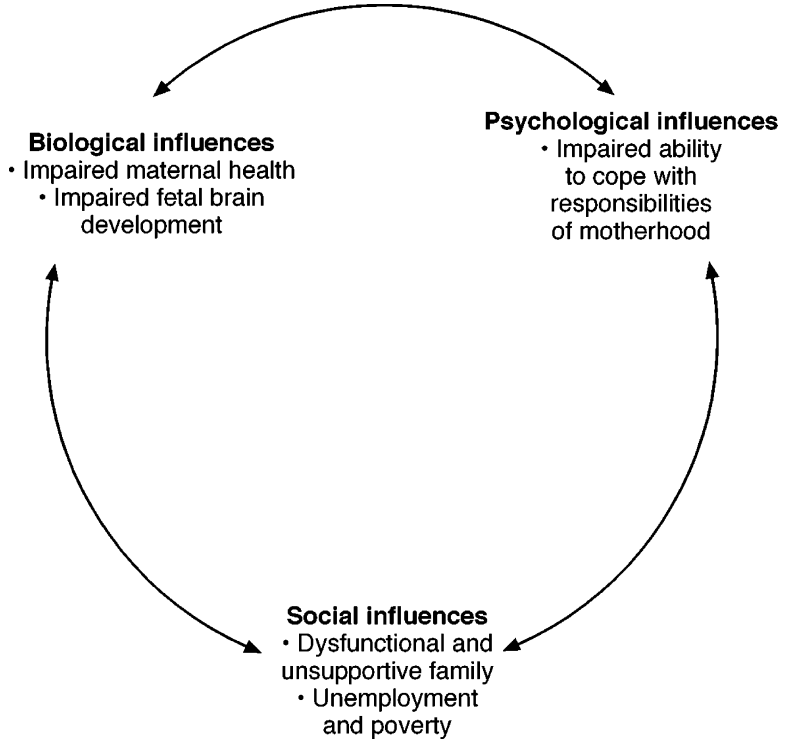

Figure 3.2. Substance Abuse and Pregnancy: An Illustration of the Action Systems

affecting dietary choices and healthy lifestyles – information, motivation, and resources – are differentially distributed in social systems. Figure 3.2 illustrates how biological, psychological, and social factors may interact in the particular case of impaired fetal brain development and Application 3.1 discusses the interplay of biological, psychological and social factors in ADHD in the cases of Allen and Barry.

With regard to the psychological, we accept George Herbert Mead's (1934) view that mind and self are social products acquired in the process of primary socialization in interaction with others, especially significant others. Biological factors may set the limits for development, the possibilities are called forth in a social setting. For example, there is ample evidence of a genetic component for alcoholism. Certain individuals inherit an intolerance, but if such individuals never take a drink, they will not become alcoholics. Family norms, religious beliefs, and peer group behaviors are critical factors in determining whether a person will use alcohol. Similarly, a child's rate of growth and development has social meaning for both adults and peers. For example, expectations of "early bloomers" often are heightened; they are often given responsible roles by teachers

APPLICATION 3.1 The Cases of Allen and Barry

Biopsychosocial interplay is well exemplified by the cases of "Allen" and "Barry." Both are young white males who, serendipitously showed up at a public mental health clinic about the same time. They have never met. Allen was 24 years old, Barry was 27. The two had similar medical histories during infancy and toddlerhood; both had been diagnosed with Attention Deficit Hyperactive Disorder (ADHD); both had about the same degree of severe learning disabilities in childhood, disorders that generally are assumed to have a biological base; and both tested as having average intelligence.

At the time of intake, Allen had graduated from high school, had since been steadily employed, and had been putting himself through college. As a part-time student, he had successfully completed a two-year community college program and was planning to transfer to a university where he would attend full time to obtain a BA degree while working part time to support himself.

Barry, on the other hand, never completed high school. While in the ninth grade, he was dismissed from school as incorrigible and was placed in a residential facility, where he stayed until he was no longer legally required to attend school. Since that time he had seldom held a job for long and what jobs he had were low skill and low paying. He has frequently been in trouble with the law, has served at least one jail term, and currently is on probation and awaiting trial. Most of Barry's problems stemmed from his lack of social skills and extremely poor judgment in choosing associates.

It must be reemphasized that Allen and Barry's disorders are virtually identical. Over the years, both have been evaluated frequently by educational institutions, psychologists, and physicians including psychiatrists. Their histories, provided at the time of intake, were obtained with their permission. The significant difference between these two young men lies in their family histories.

Allen was raised by his mother and father who were supportive throughout his childhood and adolescence. In addition to providing a nurturing environment, encouragement and help, his parents were Allen's advocates. They went so far as to bring a lawsuit against the local school system, which had refused to provide Allen with special educational services, even though the school system's test data showed that he more than met state criteria for the highest level of services for hyperactive and learning disabled children. Despite the legal costs, the family persisted with the suit and won. Allen is independent, yet his family, including Allen, his parents, and two siblings, remains close knit.

By contrast, Barry's father, who was physically abusive both to Barry and his mother, rejected him early. Barry's parents divorced when he was about five years old, and his father, a successful businessman, provided child support, but little else. He remarried, divorced, and remarried again. After divorcing Barry's mother, his father had little to do with Barry. In what contact there was, he gave Barry messages about his failures and inadequacies. Today, he generally refuses to have much to do with Barry or to help him in any way.

Instead, he denigrates Barry as worthless and no good. Barry's mother, who tried to be protective, admittedly never understood his problem, and was unable, as a single parent, to cope with Barry, despite the fact that she was financially comfortable.

The similarity of the disorders shared by these two young men is remarkable, as is the difference in their socialization experiences and in their life courses. While biological and psychological factors may establish possible outcomes, social factors interact to affect the course of personal development.

and others, which, in turn, affect their peer group status (Newman & Newman, 1984:280). These factors influence children's definitions of self and their expectations of their own abilities.

Other biologically determined features of an individual also have social meaning. Race, gender, size, and looks (attractiveness) result in a variety of social responses that help shape persons' thoughts about self and shape their actions as well. While most racial and ethnic differences are trivial, the norms of ethnic stratification within a society have broad implications for the life chances of ethnic group members. The attention-deficit hyperactive child or the learning disabled child may behave in ways that he or she cannot help. However, the reactions of adult caretakers (parents, grandparents, teachers) of such children are crucial to the course taken by their disorders.

Our approach to individual behavior includes the following set of propositions. First, that *behavior is voluntary*. People are active constructors and participants in their everyday lives. They are not simply propelled, robotlike, by "forces." At various times, theorists have offered deterministic models of human behavior, proposing that biological, social, economic, or environmental forces determine human action. We do not agree with these views and begin with the basic assumption that the actions taken by an individual are the result of a *decision or choice from among available options.*

The key here is "available options." A course of action can be followed only if it is available. An option is available if it is known by the person. Even if it is known, the person must have the resources, the necessary skills and materials, to follow through. In addition to the knowledge of options and the skills and resources required, the person must also define the course of action to be desirable, and result in valued outcomes.

The second proposition is that *behaviors are learned* as the person interacts with the environment. The consequences of actions are particularly important in maintaining them. As the actor interacts with the environment, certain actions come to be associated with preferred outcomes, or at least with the lesser of evils. Behaviors associated with preferred outcomes are those most likely to appear. In this context, it is important to note that "behavior" includes cognitive activity. Meanings, values, beliefs, knowledge, and attitudes are acquired or learned. Thus,

actors' characteristic patterns represent their adaptation and accommodation to circumstances as they define them.

The third proposition is that *learned behaviors are chosen* according to the actor's definition of self and of the situation. Behavior does not "just happen." It takes place in context. Behavior is chosen by actors on the basis of their understanding of the context and of self-in-context. This understanding is derived, in part, from negotiation in interaction with others. The situation places constraints on this negotiation. Behavioral choices are influenced by the demands of the situation and actors' preferred outcomes. Humans reconstruct reality, internally. This internal representation acts as a guide for understanding reality and selecting behaviors in response to this understanding. People are also capable of planning ahead, to construct alternative realities internally and choose a course of action from among them.

The fourth proposition is that actors' *social group memberships act as constraints* and key shapers of all of the above. By social group memberships, we mean macro–, meso–, and microlevel social groups. Social organization is the most pervasive and universal tendency of human beings. (Perhaps so self-evident that it often is overlooked). Emile Durkheim (1893/1966) believed that groups are *sui generis,* entities in themselves, that cannot be understood from analysis of individual members, no matter how thorough such an analysis might be. As members of a group interact, they actively construct a social reality; they call forth and shape the roles they need, selectively approve and disapprove ideas and actions, create and shape relationships among members, and establish and enforce rules of thought and conduct. The social arrangements, on the sociocultural as well as the interpersonal level, structure the options available to members and influence the value assigned to various available behavioral choices.

The fact is that all humans are born into an ongoing and established social order. Within that social order are widely shared definitions of what is good, desirable, and proper. As we grow and develop and live our lives, we interact with others who represent their conceptions of the social order to us. We are taught the language of our group. We are also provided with material about ourselves from which we construct conceptions of self. We learn from observation of others, from their overt socialization messages, and from their reactions, how to define situations, what to value, what outcomes to prefer, and how to conduct ourselves in various everyday life situations to obtain preferred outcomes. The established norms and values of the larger society provide the background within which specific groups – families, peers – teach us specific definitions of self and context, as well as specific norms, values, and role performances. Though a seemingly infinite number of constructions can be placed on situations, and an infinite range of behaviors is possible, it is through their cultures, the norms and values of specific social groups, and definitions of social reality that people have learned to channel their behavior into a finite range of options.

Behaviors are learned within a social context and chosen as deemed appropriate for self in the specific situation. As a result of learnings, the larger sociocultural setting and the specific group memberships establish that certain responses to

situations have a greater probability than others. But, it is not deterministic: actors have the capacity to renegotiate their social reality, constantly, as they interact. When a person's usual response to a situation is not working, the person has the capacity to seek alternative strategies and adapt to the situation.

At birth we enter an existing social system and are shaped through primary socialization. Membership in a family and other primary and secondary groups, location in a community, a culture, subculture, and a social class status contribute to and maintain present behavior and influence change and development. We actively participate in the process by assembling the materials of experience to construct a unique definition of self and of social reality. The developmental possibilities are infinitely diverse, but the social context in which we develop imposes constraints and makes certain developmental paths more likely than others.

Contextual influences range from the macrosocial to the microsocial. The times, the individual's placement in history, and the social, political, and economic forces and movements present establish the influences on life chances and our construction of reality. Consider, for example, an African American woman in her early thirties, college educated, living in San Francisco compared to her grandmother, now in her mid-seventies, born in the 1930s and raised on a farm near a small town in Georgia, educated to the fifth grade, eventually migrating to Baltimore as a young woman. For most people in the United States, even this brief description is enough to conjure detailed scenarios of the different life courses of these two women. Social, political, and economic factors in the half-century between their births presented a different context for the granddaughter. Changes in race relations and opportunities for women, technological changes, economic changes, and correlated changes in norms and values have presented the granddaughter with a different world to adapt to, different materials from which to construct herself and her reality.

Macrolevel realities are mediated and interpreted within day-to-day microsocial settings. Interactions with family members, at school, on the job, in the community, within a peer network, and even in an Internet chat room provide more specific materials for the person's self-construction. The people we interact with have understandings and expectations that place a demand on us and call for creative adaptation. Throughout life, each of us works to develop an accurate and acceptable identity, cope effectively with situations, and meet our needs. We approach these tasks as "naïve social scientists," forming and testing hypotheses about how to be and how to act. Our hypotheses are tested in social settings. We judge ourselves and our actions against the reactions of others. The things that are perceived as "working" for us are incorporated into our behavioral repertoires.

In this way, we develop fairly elaborate patterns, modules or sequences of behaviors that involve thoughts, feelings, and actions with respect to self, others, objects, and situations. The sum total is our cognitive map of reality, our basis for patterning behavior and our program for adapting to situations and settings. Consider the commonplace activity of going to the supermarket. If analyzed carefully in detail, the event involves *planning, negotiating* the aisles to find and *identify* the products sought, *interacting* with the various role-players—the market's

employees and the other shoppers–*completing* the financial transactions, and *leaving* with the packages. The sequence involves a complex interplay of thoughts, feelings, and actions that include a host of norms and role performances and it is usually all performed more or less automatically. Like most of our behavior sequences, this one has been built up over time as we observe models and interact with other members of our culture. Our own trial and feedback experiences also contribute as we try certain behaviors, observe what happens, and keep those behaviors that work for us.

As sociological practitioners, we conceptualize the individual as a social unit. We agree with Warren Dunham (1982) who considered " . . . the analysis of one human personality as a social unit with respect to the ingression into the psychic of various types of social experiences that emerge from the person's involvement with ecological structure, historical events, interpersonal relations, and cultural patterns." Who we are and how we act is conditioned by the social settings and relationships that we had to learn to respond to. Whatever the make-up of part of one's personality, the reality is that the typical patterns of behavior—both the adaptive and the problematic—are available for the reaction and judgment of others. These reactions, actual and anticipated, shape behavior. What is more, the individual is always acutely aware of and frames behaviors considering the real or imagined judgments and reactions of others.

The structuring formula for sociological practice is set by clients who seek the professional because they are faced with problems that they cannot solve with their own resources. The person enters into a new social relationship with the clinician to seek a remedy to the problem. We now turn to consideration of intervention at the microlevel.

Microlevel Intervention

It is not possible in one brief chapter to include the full range of microlevel problems and interventions. There are general considerations, however, that can guide the work of sociological practitioners at this level. Our approach will be to discuss these in terms of four problem solving stages: *assessment, program planning, program implementation*, and *program evaluation*.

Assessment with individuals: Assessment begins with the presentation of a problem by a client. The purpose of the assessment is to determine the physical, personal, familial, and socio-cultural bases of the problem and the relative importance attached to each. Assessment is a research task. The assembled data will lead to: (1) an *operational definition* of the problem; (2) a *formulation or theory* of the factors that contribute to the presence of the problem and/or maintain it; (3) a *hypothesis* about what approach(es) to take toward problem solving; and (4) *evaluation procedures* to test the hypothesis, that is, to test the effectiveness of the intervention.

The assessment stage should begin with whether to take the case. The issue turns on several questions. The first is whether the case is within your range of

skills and qualifications or those of the practice organization. Some sociological practitioners have obtained additional training and certification as social workers, mediators, marriage and family counselors, or substance abuse counselors. However, cases requiring medication or other forms of medical supervision are beyond the professional scope of sociological practitioners. Similarly, cases that require special expertise in techniques of education for physically or mentally handicapped persons should be considered only if the sociological practitioner has such expertise, cooperates with, or is part of a team that includes experts in these areas.

Another question to ask yourself is, Do you want this case? Taking a case is a commitment of your time, energy, and skills. Ethical practice requires that clients get the best service you can provide which requires your whole-hearted attention. Practical matters are relevant here. Do you have the time, energy, and resources to devote to this case? This needs to be assessed in terms of the other demands on you.

Your interests are also relevant. Most practitioners – if they are honest with themselves—are more interested in some kinds of cases than others. Or, after the tenth case of truancy in the past year, your reaction to the present case may be, "Oh no, not another truancy case." If you are not interested, you may not be able to give the case the attention that it deserves.

Work with clients requires the ability to apply your best dispassionate judgment. Your values and personal issues may be involved in deciding to take a case. If the nature of the clients or the issues involved engage critical values or would cause intense values-conflict, this may not be an appropriate case for you. In addition, to the distress you may experience, your communication with clients may be adversely affected or you may unduly and inappropriately influence clients' decision making. For example, in domestic violence cases, the issue, of course, is to put an end to the violence. But, if the issues engage your own unresolved experiences, or you are angered by persons who batter or abuse their partners, spouses, or children, and feel that they deserve only the harshest punishment, your own feelings can be a barrier to effective work. Your repugnance may interfere with your ability to listen, communicate effectively, and influence positive change. An intense personal commitment to either the Pro-Choice or the Pro-Life movements may make you an inappropriate counselor for clients struggling to decide whether or not to terminate a pregnancy. No practitioner can be value free. Our own experiences and our values, as they evolve, can be a resource in our work. But when they are a potentially negative influence in a particular case, it may be best to acknowledge this fact and refer the case to someone else.

This brief survey of preliminary assessment issues calls attention to a question often neglected: Should you become involved with this client and this problem? Many sociological practitioners, especially beginners, seem to feel an obligation to take all cases that come to them. We are often prompted to take up this line of work out of a strong concern for people's suffering. But we have to learn that we cannot always be effective with all cases that come to our attention. We need to be able to say, "I can't help you," and do so without guilt. Recognize also, that deciding to take a particular case may mean not taking other cases that may have greater need or that we can work with more effectively (See Table 3.1).

TABLE 3.1. Quick Reference: Questions to help you decide whether to take a case.

1. Is this case within your expertise?
2. Does this case create a values conflict for you?
3. Do clients or problem cause you an intense reaction?
4. Are you interested in this case?
5. Do you have the time, energy and resources necessary?
6. Are there going to be distractions or competing demands on you?
7. Does this case invoke unresolved personal issues?
8. Are there conflicts of interest between this and other cases or clients?
9. Will you be able to help?

Most of the time you should be able to assess fairly quickly whether or not this is a case you can or will take. If you decide not to take the case, this should be stated early. Your obligation is to assist the prospective client in identifying resources that will be helpful and to help them with the referral. The focus changes. The goal becomes finding the best referral or a range of options and assisting the client in gaining timely access to the services needed. Sometimes, the correct referral is a major contribution to helping clients solve their problems. To fulfill, completely, your responsibility to clients being referred requires making sure that they can use the referral. Sometimes this involves only making a phone call and helping the client set up an appointment. Other times it may involve assessing barriers and working with the client to overcome them. It is also useful to follow up to make sure that the referral was appropriate, that they got there, and can work together effectively.

Once the decision is made to take the case, we move on to more detailed assessment. You must work with the client and any other significant role-occupants to assemble as much relevant data as possible so that you and the client can come to a shared understanding of the problem and can begin, jointly, to plan steps to alleviate the problem. The task, citing Dunham (1982) again, is " . . . the examination and analysis of an individual social unit, the personality." And the objective " . . . is to arrive at a judgment, supported by evidence, concerning the nature and influence of the environmental factors—physical, social and cultural—that contribute to the explanation of the organization and behavior of the personality under examination."

It may help the discussion to have a case in mind. So, let us introduce "Tony," age 14. No confidentiality has been compromised. Tony is not a "real" person but partly a composite of the many children and adolescents that one us (HR) has worked with over the years. Some details have simply been made up for our purpose here. Follow Tony's story in the Applications 3.2, 3.3 and 3.4 in this chapter. Our need to be brief and to illustrate points may make it all seem neat, simple, and tidy. It never is.

For the purpose of discussion, assessment will be divided into process, structure, and content. *Process* refers to techniques that can be used. By s*tructure,* we mean the form, and by *content* we refer to the types of information sought. Each will be addressed in turn.

APPLICATION 3.2 The Case of Tony

Tony is a 14 year old white male, the son of Fran and Bill. He has an older brother, Sam, aged 17. Tony has been referred by the guidance counselor at the Middle School where Tony is in the eighth grade.

Brief Background: Tony's parents separated when he was four years old and eventually divorced. Fran became the custodial parent. About two years later Fran remarried and she and husband, Warren, have a child, Andrea, now age six. Tony and Sam lived with Fran in a distant city. About three years ago, when Tony was about to enter the fifth grade, Fran contacted Bill insisting that he take custody of the two boys. She stated she could no longer cope with them or control them. In addition, the boys' behavior, problems with school and with juvenile authorities had been a source of conflict between Fran and Warren.

Bill, who also had remarried–wife, Doris–accepted custody. Bill and Doris vowed to "get these boys straightened out." Sam and Tony moved to the town were their father lived, about three hours travel from where they had been living, and were enrolled in the local schools. Tony went to fifth grade, Sam to the eighth grade, both at the Middle School.

Presenting Problem: The initial meeting was attended by Bill, Sam, and Tony. Bill announced that Tony was the problem. In particular, Tony did not want to go to school and did everything he could to avoid going to school. When he did go to school, he was in constant trouble and had three suspensions of from one to three days. He is also a discipline problem at home. That is, at home he rarely does what he is told to do, including homework, and "does not listen to anyone." Overall, Tony was described as lazy, irresponsible, impulsive, always wants his own way, and does whatever he wants without thinking about the consequences of his actions for himself or for others.

Process: Techniques Useful in Assessment

Basic Process: Interaction with Clients: The most basic element in work with clients, not only during the assessment, but throughout, is the interaction and the relationship that you offer. The course of the substantive work of problem solving depends on the formation of a positive working relationship with clients. "Forming positive relationships with clients is as much art as science. It involves coming to the encounter with certain mind sets, a few techniques, the ability to 'read people,' and the flexibility to adapt interaction in response to others behaviors." (Rebach, 1991:81)

The process of all intervention work is the dynamic interaction between you and the client. The work of problem solving, the activities and techniques used, depend for their success on the quality of the relationship that develops between you and the client. For you to conduct a successful assessment and continue work beyond that requires that clients trust and are willing to work cooperatively with you. During the assessment, your task is to develop as much information as

possible. For clients to be willing to offer information, they must trust you, feel that they are safe in disclosing to you, and feel that their information is safe with you. From the assessment, you must come to know and understand the person. You must not only understand *about,* you must also understand *with.* The former, understanding about, is the "expert," the outside observer's understanding of events and conditions in an analytic sense. The latter, understanding with, is an empathic understanding—of being able to understand what the world looks and feels like to the client. It is akin to Max Weber's concept of *verstehen;* you have it when you can put yourself in the other person's role, when you can accurately and consistently predict how the person will respond to situations. It helps if the client can risk being open and honest with you.

The relationship with clients, like all social relationships, emerges from interaction. Your behaviors will affect their response. In a very real sense, the relationship you get is the one you asked for by the way you communicate with the particular individual. You will need to develop skills of observation, of active listening, and effective interviewing. More important, you will need to learn to adapt your communication in context. The conditions you present depend on how you view clients and how you define the client-practitioner relationship.

The client comes to you because of a problem. But the person is more than a problem, more than a case. The person is not a static entity to be categorized in terms of "pathology" or deviance. At the outset, it is important to focus on the uniqueness and complexity of each person who comes to you. Differences in cultural and ethnic background, age, gender, social class, religion, all affect how individuals construct experience and how they interact and form relationships. Their own life experiences add to their uniqueness and complexity. Each individual will also have a personal style: Some are more concrete while others are more comfortable with abstractions. Some are more open, others are more guarded. Some are more inner-directed, others are more external or other directed. Some are quick to grasp ideas and skills, others are slower. Some are more and some are less reflective and insightful. You need to be aware of differences and adapt your communication to these personality differences.

Of all possible approaches to relationships with clients, we suggest that the "client centered" approach of Carl Rogers (1951) is the most consistent with humanistic values and with effectiveness. This approach is not unique to sociological practice but is useful for all invervention disciplines. It involves showing genuine concern, acceptance, warmth, non-judgmental respect for the person, honesty, and empathy. The relationship is a partnership between status equals; it is non-directive, non-controlling. (The fact is you cannot make anyone do or be anything. To attempt to do so will create antipathy and resistance.)

Though you will eventually focus on "a problem," you must see the client as someone who has strengths and resources that must be acknowledged and learned about. The person also has a history, is a member of various social systems, and has roles and interacts within them. The person is striving to be effective and solve problems, is striving for positive social relationships within social contexts, and is attempting to maintain dignity, a positive definition of self and to have

some control over life. The person also has a range of feelings, values, expectations, and goals.

The relationship of status equality requires respect for the person's individuality and autonomy. People should be understood as capable of self-determination, of acting in their own best interest, capable of making choices. People are also capable of learning and growing and of solving problems. Respect includes refraining from moralizing, judging, criticizing, or blaming. Avoid lecturing, advice giving, arguing, analysis, interpretations, threats, and warnings (Hepworth & Larsen, 1986:86). The goal is a partnership over a "shared concern" (Lane, 1990:124) where you and the client take agreed upon roles in problem solving.

As you begin with a client, some consideration of initial interactions is useful. Anticipate some anxiety and attempt to reduce ambiguity by outlining the procedures. Explain your role, the sequence of events, and any agency or organizational requirements that you must meet. It may also be useful to address any strong feelings that are evident at the moment. Authority relations are an example. Some people may be over-deferent to those they perceive to be authority figures while others may be resentful. Non-voluntary clients like Tony are often hostile and sullen. Addressing these feelings directly and negotiating a place to start is essential if the interaction is to proceed productively.

The task of assessment is to assemble as much relevant data as possible. One obvious source of data is the interview with the client. A place to start is with the presenting problem. Listen carefully to clients' statement of the problem. This is their construction of their reality. In their statement of the problem, they will reveal their theoretical formulations about what is wrong, their theory of causation, their explanation of its effects, and the list of co-actors who are significantly involved, and the nature of their involvement. Listen also to the form as well as the content of their recitation. Take careful note of illogic, fuzzy thinking, and ill-formed statements. Jot them down or file them in memory for later clarification.

As an example of this last point, consider the client who arrives at your office, on time, well groomed, is employed, has a family, and announces, "I can't do anything right." As a matter of content, the client is stating a perception about self, perhaps a perception of interaction with others, and/or perceptions about handling specific recent or earlier life events. The statement may reveal fuzzy thinking and is not well formed. First, it is illogical, not consistent with observable facts. The client managed to find you and arrive on time (got here, maybe using public transport or drove, found a place to park, etc.) In addition, the client is functioning as an employee (has not been fired) and a family member. It is likely that the client is doing (and is capable of doing) some things "right." The statement of "allness" reflects the client's deletion or selective failure to recognize areas of effectiveness and reflects selective emphasis on the negative, which adds to the fuzzy thinking. It will be important to discover if such deletion is a characteristic pattern. The statement is also incomplete. What is it that this client cannot do right? When? Where? And, importantly, what does "right" mean and whose standards is this client applying? These will become issues for follow-up and further investigation.

Taking a life history is a useful method to expand understanding of the problem behavior. The objective is to learn about the client's primary socialization experiences and the family culture. It should begin with the family of origin and work through the life cycle stages. The life cycle stages provide a handy framework for the life history. A technique that can also be useful is to construct a genogram with the client.

A *genogram* is a multi-generational pictorial display of a person's family relationships. It goes beyond the traditional family tree by allowing the user to map out and visualize hereditary patterns and social and psychological factors that punctuate relationships that might otherwise be missed on a pedigree chart. It can be used to identify repetitive patterns of behavior and to recognize hereditary tendencies. Genograms were first used and popularized in clinical settings by McGoldrick and Gerson (1985). Genograms are now used by professionals in medicine, psychiatry, psychology, social work, sociology, education, genetic research, family therapy, and in disease risk counseling. Figure 3.3 provides an abbreviated example. It starts by locating the client, then spouses, children, siblings, parents, and grandparents and trying to elicit what is known about the family members identified and about their relationships.

From the family background, the life history progresses through the early stages: Prenatal, infancy, toddlerhood, etc. Many people have heard family stories about themselves and their families. Most people will have their own memories from the school years, adolescence and beyond. Key issues include family relations, peer relations, school experiences, academic performance, parental expectations, religious and moral teachings, health and mental health, developmental problems, rate of development, romantic and sexual experiences including possible experiences of abuse, use and abuse of alcohol and other drugs, and periods of stress. It is also useful to focus on the handling of transition periods such as starting school, onset of puberty and the adolescence-to-adulthood transition. A focus on the developmental periods in sequence helps the client keep the history organized and aids recall.

Additional sources of information should also be considered. These include interviews with significant others, direct observation, the use of questionnaires and rating scales, and the use of archival data.

Interviews with significant others: Family members, friends, co-workers and supervisors, teachers and other school staff, and various members of a person's social network may provide useful information on the nature of the client and the problem. Their feelings, attitudes, and reactions may figure into the definition of the problem and may provide alternative views of the client's lifespace. As labeling theory suggests, "deviance" may be the product of observers who have the power to label and stigmatize the person and make their labels stick. These persons may also be a resource as potential providers of social support for the client's efforts to change. They may also play a role in maintaining the problem and may eventually have to change their ways of interacting with the client to facilitate change. You must be sure to get the client's written permission to talk to these people. Some clients may be unwilling to give permission. Often such refusal is

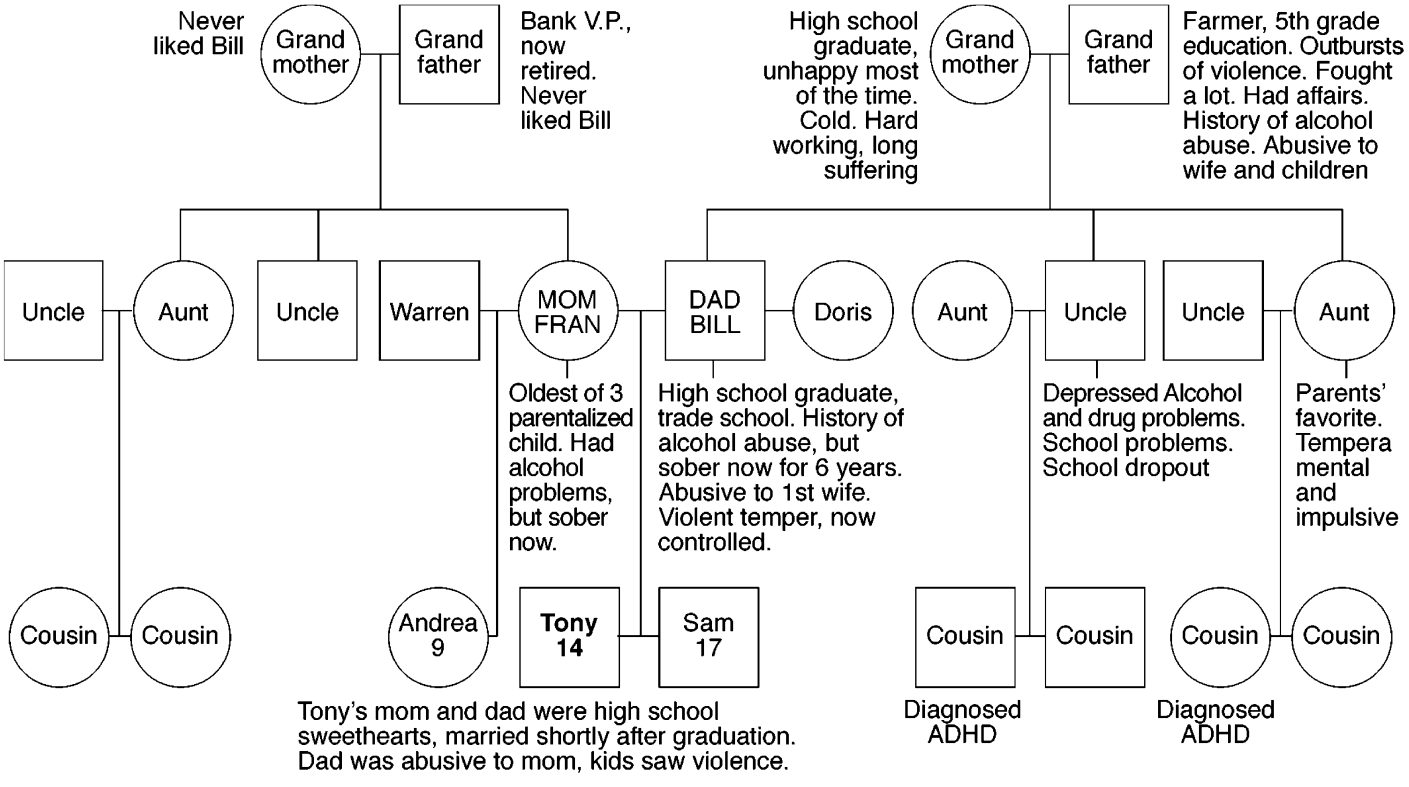

FIGURE 3.3. Example of Genogram of Tony's Family

accompanied by a fear of reprisal for disclosing "family secrets" as in cases of abuse or domestic violence.

Direct Observation: Observation of behavior in relevant settings—at school, on the job, at home, etc.—provides information about the pattern of the person's typical behavior and interactions. Such observation will also permit assessment of the client's environment and social context. Be aware that the client and others being observed may be influenced by the presence of an outside observer and may attempt to modify their actions and they may even be successful at it for a short time. However, the norms and culture of most settings will make it difficult for them to radically alter their habitual patterns and keep it up for a long time, so plan to stay long enough or return often enough to get a reasonably good set of observations of the context. Here again, it may be necessary to obtain written permission. Note, however, that even with written permission, obtaining cooperation may be difficult. The degree of cooperation may depend on how vulnerable managers and supervisors might feel about outsiders' observations. There may also be legal constraints as well.

Questionnaires and Rating Scales: Parents, teachers, co-workers and supervisors, partners and spouses, and even the individual client may be able to provide their perceptions using standardized paper and pencil instruments as a way of providing data. An instrument like the Symptom Checklist-90 Revised (SCL-90R) (Derogatis, 1983) helps to evaluate a broad range of psychological problems and symptoms of psychopathology in a short time. The Social Readjustment Rating Scale (Holmes & Rahe, 1967) is a useful source of information on the kinds of life events that cause stress in people's lives and the amount of readjustment life event changes requires of them. A variety of questionnaires and checklists exist for both parents and teachers to provide information on children and youth (Achenbach & Edelbrock, 1983, 1986; Barkley & Edelbrock, 1987; Conners, 1973). Hollon and Kendall (1980) constructed a useful questionnaire, The Automatic Thoughts Questionnaire, to assess the frequency of various troubling cognitions. The Social Performance Survey Schedule (Lowe & Cautela, 1978) is another useful questionnaire that may be filled out by the client and by others who know the client. It presents a list of behaviors; respondents check how often the behaviors occur. It is also possible to construct questionnaires for specific cases. Asking clients to keep a diary of specific behaviors such as eating, emotions, smoking, can be helpful, especially if they are provided with a structured format and guidance on what to record and how. Unstructured journals or diaries kept by clients can also be a useful source of information about feelings and responses to them associated with certain events.

Archived Data: In today's corporate world, most people have a paper trail. School records, psychological reports, work records, educational test records, medical records, court and police records, military service records, can all be sources of useful data on clients and their problems as well as on their strengths and resources. It is also necessary to secure written permission to have access to these materials.

Structure of Assessment

Assessment should include a detailed description of the problem behaviors and variations of them. Along with the analysis of problem behaviors, an analysis of their antecedent conditions and consequences should follow. Figure 3.4 provides a graphic flow chart of the assessment framework.

The term "antecedent conditions" refers to those things that precede instances of the problem behaviors. It includes those things that bring them on, make them worse, or make them better. Sequences of events or stressors may lead up to a specific cue or trigger for the occurrence of problem behaviors or exacerbation of behaviors to the point of their becoming problematic. These antecedent conditions may be some combination of events or circumstances, social contacts or social situations, role relationships or settings, thoughts, feelings, internal self-speech, or physical reactions. The question might be phrased: "Who does what under what conditions?" It is also important to know what makes things worse and what seems associated with an easing of the problem. The latter may prove especially useful in providing direction for problem solution.

Assessment should also examine the consequences, both manifest and latent, that follow from the problem behaviors. What events, or reactions by whom, keep these behaviors in place and/or work against alternative behaviors appearing? Problem behaviors emerge, generally, as actors try to adapt and achieve goals in a context. But the factors that have shaped the behaviors may be separate and distinct from those that maintain them. Thus, a hyperactive child may have a teacher who understands the disorder and can work with the child. On the other hand, a less patient and less knowledgeable teacher may define the child as "bad" and place demands that the child cannot meet. The latter response may have the effect of accelerating problem behaviors.

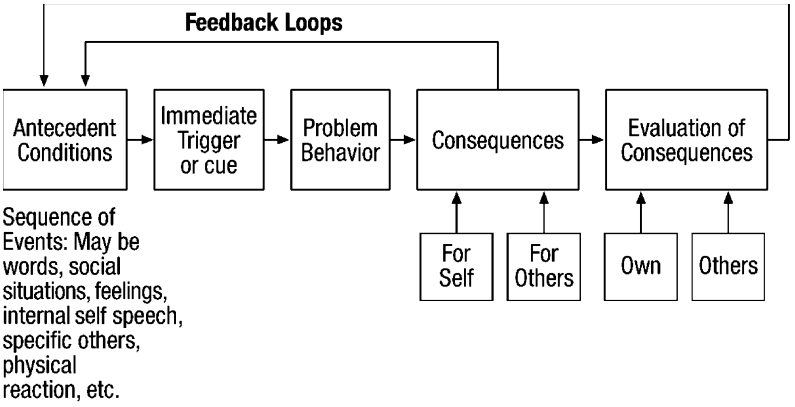

FIGURE 3.4. Flow Chart of the Assessment Framework

Application 3.3 illustrates how Tony's response to his task engaged his sense of personal worth given his estimate of his peers' evaluation of him. The problem arises when behavior deviates from the norms and expectations of the school and the larger social system, and affects Tony's family as well.

APPLICATION 3.3 The Case of Tony continued

The presenting problem with Tony, a 14 year old in the eighth grade, is "school refusal." That is, he does everything he can to avoid going to school. In addition to the effect this can have on his future, it is an immediate problem for his parents. Thus, the problem behavior is Tony's avoidance of school. He has had four suspensions in the first half of the school year. Tony has also learned how to get himself suspended. One technique that worked for a while was to curse-out a teacher. When that stopped working, he found other methods. When asked why he did not want to go to school, Tony's typical reply–the worst thing he could say about anything–was, "cause it's stupid . . . the teachers are all stupid."

Consultation with Tony's teachers revealed that, in classes or situations where students worked on group projects, Tony was well behaved, contributed to the group effort, got along well with the teacher and the other students and clearly showed intelligence. However, when he had to do work on his own, he quickly stopped working and withdrew into himself. When pressed by a teacher, he got sullen, argumentative, and defiant, eventually abusive toward the teacher, leading to ejection from the classroom and being sent to the principal. Abusive language from Tony accelerated when he got to the principal's office. This sequence led to further avoidance of school.

The payoff for his frequent truancy and suspensions was successful avoidance of what was, for him, a frustrating and aversive situation. He stated that, unlike the other students, the work was too hard for him. He also noted that since he was the only one who could not do it, he feared appearing stupid and receiving ridicule from classmates–something to be avoided at all costs. The sequence of antecedent conditions appeared to be: reading task--> feelings of inadequacy frustration--> anger--> abuse toward authority figures--> disciplinary action--> suspension successful avoidance.

Content of the Assessment

The assessment is a search for information that will provide an understanding of the client and the problem and point the way to program planning and implementation. As we turn to a consideration of the types of information to be sought, be aware that we cannot give a step-by-step guide or indicate the order in which topics are to be addressed. Experience has taught us that information does not come in neat packages with topic headings. It usually comes in bits

and pieces that must be organized and integrated. Here, we offer questions that may eventually help you to organize your material. What follows is meant to suggest the kinds of things to know so that you will be able to plan a program of problem solving.

Clients' statements of presenting problems are statements of why they are seeking help. It is important to know what they have done previously to address the problem and why they are seeking your help now. They may have tried to solve the problem on their own. Usually their attempts at problem resolution are consistent with their personal theory of the problem, its causes, and its consequences. They may have sought professional help before. If previous attempts had worked to their satisfaction, they would probably not be seeking your help. Explore what they have tried and what the results of their efforts have been. What effects have previous efforts had on the client and what have been the effects on others in the client's social system? Such information will be useful in planning the intervention.

Also, explore why they are seeking help at this time. Have they reached an impasse or is there some crisis that made previous adaptation no longer workable? Or, are they satisfying the demands of others such as spouses, partners, or parents? Are they prompted by involvement with agents of formal social control such as school, court, or juvenile court personnel? It is not uncommon for non-voluntary clients to state that they do not know why they have to come and that they have no problem. The answer to the question, "Why are they here and why now?" may significantly affect clients' motivation, their response to you, how you establish a relationship with them, and the nature of the intervention program. If the client does not believe that a problem exists, or are unwilling to consider changes in their life, these are issues that should be addressed.

The assessment is organized around the presenting problem and it represents the point of departure. Find out what ideas the client has about the problem. Elicit feelings and actions as well. Probe what relationships are involved. Discover all you can about the client's intentions and subjective reality. Does the client have a metaphor or visual representation of the problem? Knowledge of these elements will help you enter the client's model of reality and provide a basis for more effective communication.

One objective is the development of a clear operational definition of the problem itself. This is often difficult because clients present problems in global or vague terms. For example, a frequently heard complaint is, "I worry a lot." Another is, "I can't get anything done." In Tony's case, the problem might have been stated as "Tony resents authority. At home he never does what he is told to do and at school he is always rebelling." Or it might simply be, "He won't go to school." None of these statements tell what he does. A clear statement of problem behaviors is required and the client must be willing to take ownership of the problem. Since problem solution involves behavior change, the problem must be recast in terms of observable behaviors by specific role-occupants.

It is important to be specific and to make connections. The task is to determine the sequence of observable events leading up to specific behaviors that are defined as problematic and the consequences that follow. In Tony's case we learn, initially, that he behaves poorly in school and tries, often unsuccessfully, to avoid having to go to school. The use of various approaches also revealed a repeated sequence of related behaviors. Tony functions well in groups but problems arise when he has to work quietly on individual tasks—what teachers call "seat work." He has trouble following written directions, usually finds written material too difficult, has difficulty staying on task, and does not stay in his seat. He often bothers other students or gets out of his seat and wanders around the classroom. Since these behaviors are disruptive, teachers try to get Tony to comply with their instructions. This prompts some retort from Tony and the conflict escalates. Eventually Tony gets ejected from the classroom and gets sent to the school disciplinarian. There, Tony becomes more abusive and eventually gets sent home. Suspension from school causes problems for Tony's parents who attempt to impose additional discipline leading to further conflict.

A useful approach is to formulate problem behaviors in terms of excesses and deficits: too much of some behaviors and/or not enough of some preferred behaviors. It may be that merely the existence of the behavior is the problem: vandalism, theft, truancy, spousal abuse, thoughts of suicide, teenage pregnancy, and drug abuse are examples. It may be the frequency or intensity of some behavior: eating is a common action, but binging can be problematic. Occasional and moderate use of alcohol is acceptable for many people, but excessive use may be problematic. Most people worry about things like finances, their health, their significant others, and many people become anxious before a test, before a trip by plane, or some other important task or event. When these worries and anxieties accelerate to become life hassles, they can become problematic.

Investigation of the problem should include identification of key actors in addition to the client. Members of the client's social system are the social context in which the client acts. They may be the ones defining the client's behavior as deviant, the ones demanding change, and they may also influence the client's present behavior. Their actions, judgments, and experiences with the client are a rich source of information on the problem. The list should include those persons who are involved in the problem behaviors and those who are in a position to influence the change process.

In addition to identifying key actors, you need to know their positions in the systems they represent and the constraints that these systems impose on them and their interactions with the client. It may be that whether the client keeps a job may be contingent on their getting help with some problem. It would be useful to know the employer's or supervisor's expectations, attitudes and reactions toward the client. What power relationships are involved? How do these actors and the client react to these power relations? You will need to know as much as possible about their involvement and interactions with the client. Specifically, do

they do anything to trigger or maintain the problem behaviors? Can they be a resource in problem solving? Are they willing or able to change their interaction with the client?

While the problem may be detrimental to some, there may be other members of the client system that derive some benefits. Change by one or more members may upset the steady state of some relationships. The members of a role-set may have a long history with an individual and have formed stable definitions and stable patterns of relating to and interacting with an individual. Change by that individual may be resisted by other members of the role-set because they are unaware of the need or do not want to change because they benefit in some way from keeping the situation as it is. For example, more adequate role performance by one or members of the client system may mean a loss of power for others. A redefinition of a child from "bad" to "learning disabled with hyperactive disorder" may be seen by the school staff as pointing to their inadequacies in the skills and special programs needed to meet this child's needs. In examining consequences, it is necessary to be alert for both *manifest and latent consequences* and for whom the consequences affect. Consequences can maintain problem behaviors and work against change.

Carefully investigate why the problem is a problem. Problems are often couched in terms of deviance from some norm or standard within a context. It helps in defining the problem to know the norms that the client deviates from. Whose norms are they? What roles do they occupy? What is their relationship to the client? What gives them the right to insist that the client conform? Are there special circumstances that bring a deviant label to this client but not others who behave in a similar manner? The label given to the client (or the way that the client labels self) influences how others understand and act toward the client. The way the client labels self also influences actions and understanding of self and the problem.

It is often helpful, in clarifying the problem, to find out the details of the circumstances surrounding the *first* recognized episode. What were the conditions at the time? Where did it happen? When did it happen? Who was present? What were their roles? How did they react? Were there specific life event stressors prior to the first instance or were any present at the time of the first instance?

It may be that the problem behaviors existed earlier and were not identified as such until they began to interfere with certain activities or came to the attention of specific agents in specific contexts. This may be the answer to the "Why now?" question. Be alert for earlier instances of the behaviors. For example, it is common with children such as Tony that hyperactivity does not come to attention until the child starts school or even later as the child advances to a grade where the tasks or expectations they face make difficulties evident.

In addition to the first episode, similar details of specific episodes, especially vivid episodes, can help clarify what the problem behaviors are and many of the issues of antecedents and consequences. Details such as time, place, who was present, and who did what should be determined. These details may also help identify the triggers that start sequences of problem behaviors.

The sequence of events leading up to instances of problem behavior, the antecedent conditions, are important. It may also help determine why the problem exists. Start with the problem behavior itself and track it back. What is the immediate precursor or trigger? It could be a setting, a person, a group, a relationship, a context. It could also be a thought, a feeling, an action, or a physical state. It could also be the result of a sequence of "self talk." Then, study what precedes this triggering event. And, what precedes that, and so on as far back in the sequence as it is possible to gather information.

The use of a genogram to obtain intergenerational information can reveal possible genetic or family culture factors that contribute to problem behavior. As you work through the life cycle stages, there are some other things to be alert for.

- *Family circumstances at each stage:* these include economic circumstances, health of members, the quality of relationships among members including power relationships, the nature of role performances, living arrangements, family solidarity, and the client's thoughts and feelings about family members at each stage.
- *Developmental mileposts and tasks:* At each life cycle stage there are developmental tasks. For a child, this includes such things as when did they walk, talk? Were there problems in toilet training? Did they separate easily when they started school? What was the process of physical maturation and growth? Early bloomer or late bloomer? When did puberty take place and what was the reaction to it?
- *Socialization messages received:* What overt messages about self did/does the client receive? What moral prescriptions were given? How was gender role socialization accomplished? What religious or spiritual training took place? What were the messages about the client's nature and worth? What were the performance expectations and how were they communicated? What feedback was given regarding meeting expectations? In general, what brought rewards and punishments? Who were the key models and how did they act?

There are also issues specific to the various stages that might be useful to know. Several life stages involve school and the school years. The following list includes items that may also help the practitioner understand the client.

- *How far did the client go in school?* How many schools did they attend? Did they drop-out and try to go back? What were the aspirations and what was the reality? What were scholastic activities, general trends in academic performance, disciplinary problems, relations with school staff and teachers, peer relations, reactions of peers and teachers, attitudes toward school and academic achievement, expectations of parents for academic achievement, interests, and career preparation if any.
- *The transition to adulthood:* Issues include sexual relations, love relationships, attitude and orientation to marriage, careers and occupations, plans, aspirations, and realities; relations with family of origin; the timing of transitional steps (e.g. age and circumstances of getting a driver's license, jobs, sex, etc.)

Specific issues to learn about include substance use—alcohol and other drugs—including age at onset, extent of use and substances used, and pattern of use in

family of origin. It is also important to ask, specifically, about types of abuse and violence. Evidence for the prevalence of both substance use and physical and sexual abuse suggest that significant portions of the population have one or both in their history. An individual's adaptation, social behavior, and thoughts about self and others and present circumstances may be significantly grounded in these experiences even though they are not identified as the specific presenting problem.

Application 3.4 presents an abbreviated version of Tony's assessment that illustrates the integration of the various sources of data. Assessment with a child like Tony involves interviews with parents, with Tony, meetings with teachers, the use of teacher report forms, and direct observation.

APPLICATION 3.3 The Case of Tony continued

Tony's early school years were difficult for Tony and Fran as a single mom with two boys. Both Tony and Sam were frequently disciplinary problems both at home and at school. Bill's visits were sporadic and he was generally uninvolved with the boys though he paid support more or less regularly. When Tony was about six Fran met and later married Warren. They had Andrea about two years later. When the boys came to live with their father and Doris, Tony was in the fifth grade. He did well in fifth and sixth grades but his progress declined in the seventh grade. There were no behavior problems until this year in eighth grade.

Alone with Tony, he described coming to live with his father three years earlier. He was unhappy about it at first, having to leave his friends behind and coming to a new school where he did not know anyone. He said meeting people was hard for him. Asked about school today, he called it "stupid" and the work was too hard. He said he only had one friend at school and that most of the other kids did not like him. At some point he was asked to read aloud from a daily newspaper and later from a third grade reader. He strongly resisted at first, denigrating the task as "stupid;" he held that, of course, he could read, everybody can read, he just does not want to. When he eventually agreed to do it, he opened the third grade reader. He appeared to have great difficulty with the third grade material. He could read some of the words but also filled in with words not in the text. He seemed to be composing sentences based on the pictures that accompanied the text and on the few words he was able to read. Thus, one hypothesis was to raise questions about Tony's ability to read as one problem. Tony was referred to the school psychologist who conducted educational and psychological testing. Educational test data revealed that Tony's reading level was about fourth grade and also revealed a possible learning disability. He usually could not follow the written directions and if the task was a reading task, he was usually unable to do the task. Discussion with Tony revealed that he had developed some strategies to cover his reading deficit and how hard he worked not to appear stupid to his classmates.

Tony was also referred to a pediatric neurologist whose examination and review of observations and teacher and parent reports confirmed a diagnosis of Attention Deficit Hyperactive Disorder and learning disability.

Assessment with Families

Families as social systems: Analysis of family functioning requires an active awareness of micro, meso and macrosocial realities. Social changes have occurred on many levels. On the macrolevel, political and economic trends have had consequences for families. For example, trends such as the shift toward political conservatism has affected structures of the welfare state including those that help maintain impoverished, unemployed, and homeless families. Demographic shifts that include the aging of the population and the influx of immigrant groups have created additional issues for work with families. The emergence of religious fundamentalism as a social and political force, increased violence, especially in cities, and homeland security precautions, all affect families and the mesolevel structures that families have been involved with. Globalization and competition in a world economy, the shift toward a post-industrial society, and the downsizing of corporations as well as the rapid recent increase in single parent families all affect families' financial outlook. Even with two-parent families, the current economic trend requires both parents to be employed. These factors not only affect families' financial circumstances, they affect parent-child and adult partners' relationships as well as childrearing and child development. While these features are not typically the targets for change when working with families, they set the context for family adaptation and functioning.

The forms of marriage and family contained within a society are related to other aspects of social organization and culture. Major influences on family forms include the economic system, the political system, the kinship system, religious system, and the stratification system. The most evident recent social change is an expansion of what constitutes a "family." Many people in the United States now live in families that differ from the monogamous and nuclear family forms. These include single parent families and *"binuclear" families*, "a group of parents and children who used to live together but now live separately due to divorce or separation." (Stover & Hope, 1993:11) Also, *"blended families,"* one or more parents bringing children from former relationships with them. Cohabiting couples, foster families, gay and lesbian families, families in communes, migrant families, dual career families, joint custody families, *sandwich generation families*, and commuter marriages add to the diversity of family forms. The variations are extensive. The various forms of marriage and family have unique cultures, norms, and expectations which may differ from the normative definitions of a short generation ago.

Sociological intervention with families is also intervention at the microlevel. Families sometimes seek professional help because they, collectively, recognize a problem in family functioning that they have not been able to resolve with their own resources. More often, a family member, such as Tony, is seen as having a problem that disrupts family functioning and provides an entry to family intervention. Minuchin (1974) and others (Ackerman, 1958; Haley, 1963; Jackson, 1965) have urged an approach to individuals' problems that considers their family and social contexts. We agree with the formulation expressed by Minuchin decades ago that a family is a social system that affects all members and that problems arise from existing social arrangements.

> . . . when a family labels one of its members 'the patient' the identified patient's symptoms can be assumed to be a system-maintaining or a system maintained device. The symptom may be an expression of family dysfunction. Or it may have arisen in the individual family member because of his particular life circumstances and then been supported by the family system. In either case, the family's consensus that one member is the problem indicates that on some level the symptom is being reinforced by the system (Minuchin, 1974:110).

A family is a social system. Attention must be given both to interaction among its members and with its external environment. To deal only with the interaction among members is to ignore the influence of vital transactions with external systems. Likewise, to focus on a family's external interactions ignores its internal milieu. Families as social systems link individuals with the larger society and serve members in many ways. One important function of families is to socialize children by teaching language, skills, knowledge, and roles they are expected to display, know, and perform.

As a social system, family members are functionally interdependent; each member and the whole is affected by the actions of each member. The way that members enact their roles is shaped by and emerges from the interaction among members. Role performances are shaped by the needs of the group and its members. Needs are those things required for the maintenance of boundaries and a steady state. Steady state, with regard to families, refers to the maintenance and continuation of the family as an identifiable unit. The members, individually and collectively, are affected by the external environment and by each other. Failure to cope with the combination of external and internal pressures that results in family dissolution is the failure to meet needs and maintain a steady state. Families are disrupted when internal and external conflicts and pressures driving members apart exceed the pressures keeping them together. That is, the social system of the family is unable to process potentially disruptive forces to maintain its integrity. Family dissolution occurs when the disruptive forces are such that the family is unable to adapt.

In general, family dissolution is not the norm. When it does happen, experience suggests that it usually comes after repeated struggles to adapt and stay together. The usual issue is not whether the family unit adapts, but what form the adaptation takes. Over time, families develop patterns, relationships, norms, and shared understandings that, at any given moment, represent their present adaptation to their internal world and their external world. Assessment involves analysis of the present system and its development.

Issues for Assessment: As with individuals, a reasonable place to begin the process of assessment with families is to determine the presenting problem. In general, the needs and problems of families are a function of their transactions with each other and the environment. Early in the assessment, basic demographic information can be obtained. Age, sex, income, education and occupation. It is also helpful to find out why this family is seeking help and why now. Have there been recent critical events or contact with outside agencies, such as

Child Protective Services, creditors, or courts, that have directed this family for services.

The goal of assessment is to identify the condition within the family system that is seen as disruptive and to clarify how it disrupts, to identify factors within the system and the environment contributing to the dysfunction. The major question for later program planning is, "What will help this family to adapt and to function more effectively?"

The nature of the problem often depends on who you talk to, so be sure that each family member has an ample opportunity to express their views. This is not always easy. Families keep secrets. Individual members may have hidden agendas. Family members may have learned that certain topics are not "safe," and may bring reprisals once they have left a meeting with the practitioner. Some family members may have a stake in maintaining the status quo and may resist or sabotage efforts to change. It is useful to determine the extent of consensus over problem definition. While these are problems for assessment, note that they are also issues, such as resistance to change, ambivalence or uncooperativeness, that may need to be directly addressed if positive change is to occur. The practitioner's efforts at establishing a climate of trust and safety are very important in this regard.

Often, families attribute the presenting problem to the deviant behavior or perverse nature of a particular member. "If only he or she would be/act different," they say, "everything would be OK." This is rarely the case. Sometimes parents, influenced by their experience with medical problems, define the child's behavior as the problem and send the child to a practitioner with the attitude, "Here's my kid. Fix him." The family systems approach offers a set of alternative hypotheses. The most general hypothesis is that systemic problems require systemic solutions. The individual's behavior is a manifestation of a systemic problem; the family's need for maintaining a steady state may require that a family member is identified or blamed as the source for dysfunction. Successful assessment and intervention may require the practitioner to provide some instruction to the family members on how systems work. Here again, sensitivity to the family members and the establishment of good rapport are necessary; for example, no parent wants to hear that he or she "caused" the deviant performance of one of their children. The task is to foster understanding and accept responsibility without blaming.

As our general model specified, a study of the antecedents and consequences of the problem is also necessary. How does the problem manifest itself? Under what conditions does the problem appear, accelerate, or diminish? What triggers instances of problem-related behaviors? Who are the co-actors in transactions that are manifestations of the problem? What effect do their actions have on the rest of the family? How does the problem and its manifestations affect interactions with neighbors, groups and social institutions the family is connected with, and perhaps the community in which they live?

As assessment begins, it is important to determine the boundaries of the family; who is in and who is out. Sometimes the determination is as simple as who resides in a household together. Thus, one family cluster involves a husband and

wife and their minor children, but many other configurations exist. For example, the addition of an aging and ailing grandparent to the household may affect the relationship between parents and children. Or, consider the case of a young single mother who lives with her parents and the grandmother takes care of the children while the mother works. Often, in such situations, the mother has difficulty establishing parental authority over her children as the grandmother enacts a mother role over her daughter and her grandchildren. Sometimes the child treats the mother more as a sibling than as a parent. Sometimes the oldest sibling assumes the role of an absent parent.

The system can grow even more complex involving parents, step-parents, siblings, half-siblings and/or step-siblings, housemates, and unrelated individuals who live together sometimes, apart at other times, or do not live together at all but are regularly involved with each other. Therefore, the determination of the definition of the client system may be a necessary early step in assessment.

Whatever the make-up of the family cluster, the life cycle approach reminds us that some attention must also be given to the family's stage of development (Stover & Hope, 1993:349). In general, family stages of development are dependent on the presence of children and their ages. Clearly, the issues and relationships of a young man and woman with an infant are different from a family such as a blended family with three teenagers. Couples who have recently entered the post-parental stage may be trying to cope with role-loss and relations with their now-adult offspring. Couples who have no children experience the family life cycle differently from couples who have children. An understanding of the family make-up and the demands of the various stages of development will help practitioners understand the family context.

Explorations of the adult family members' socialization for family roles is another important step in the assessment. An interesting feature of our modern society is that we educate and train people very carefully for many of their roles yet generally neglect training for familial and parental roles. Socialization for family and parental roles is most often based on the models that the adults had and the way they themselves were parented. This is one explanation for the common finding that abuse tends to run in families. Experience suggests that individuals often choose as mates persons similar to their own family of origin, sometimes, over and over again.

Assessment should include determination of relations with extended family members. In our highly mobile society, nuclear family units are often at some distance from extended family members and contact is sporadic either by choice or by necessity. But close extended family relations can be a source of social support and a buffer in coping with life-event stressors. Extended family members can be helpful in providing child-care, may be able to provide material assistance in an emergency, and may help simply by offering emotional support and advice in times of family conflict or difficulty. On the other hand, extremely close relations with extended family members may be part of the problem. This information is an important part of the analysis of the boundaries of a family system.

In addition to contact with the extended family, it is useful to determine the family's contact with other systems. These include employers, religious organizations, community, neighborhood, social and ethnic organizations, schools, and voluntary associations. Specific attention should be given to involvement with agents of social control such as police, courts and social services agencies. These organizations may be related to problem development and/or provide resources for problem solving.

The primary focus of family systems analysis is the relationships among family members, the sub-systems of the family. Martin and O'Conner (1989) noted that a family of five can have 25 sub-systems in addition to its core system of five members. These include every combination of mother, father, and three children. Alliances and coalitions form and change throughout the life cycle of families. Practitioners are concerned with family sub-systems because they exist in all families and are sometimes denied, distorted, or conflicting in families with problems. The number of family sub-systems increases geometrically with family size.

Family assessment requires an understanding of the concept of "*wholeness*" as discussed in Chapter 2. The system is more than the sum of its parts. The entire family "owns" the problem. The practitioner needs to assess the family as a social structure, as a whole social system. Hepworth and Larsen (1986) provided a detailed description of family assessment from the social systems perspective. The key elements are the sets of family rules and the relationships within the family. Relationships involve the role structure, the distribution of power in the family, the communication patterns, the family's approach to problem solving, and the affectional structure.

Family Rules: Families, like all social systems, are rule-governed. Rules evolve in the negotiation of family roles and expectations. They include rights, duties, behaviors, ways of relating, and ways of interacting. The rules are expressed as patterned and predictable organized responses to situations. For assessment, practitioners should go beyond content and observe the regularity of patterns of action. For example, if we observe that every time John or Mary express an opinion about something, the other immediately disagrees and expresses the opposite opinion, we have learned something about the rules of their relationship, especially regarding competition, dominance, and control.

There are both overt, published rules and implicit rules. The overt rules usually are explicit statements about what must be done, what may be done and what is forbidden. They specify the expected actions in specific situations of various role occupants. The overt rules for children are often the subject of child discipline. Examples are activities or tasks for children like bedtimes, household chores such as keeping your room clean or taking out the trash, use of the family car or telephone, doing homework, and having friends in the house.

Issues for assessment include finding out what these rules are, the consistency with which they are enforced, and the sanctions and consistency of sanctions for violation. The overt rules are often a source of parent-child conflict. As children develop, they may feel that certain rules, established when they were younger, should be changed or no longer apply. Assessment should attempt to determine whether rules are renegotiated and if so, how they are renegotiated. For example, early bedtimes are often considered appropriate for younger children while some

families allow older adolescents to set their own bedtimes. Discovery of how such changes occur is useful in understanding how families adapt.

Discovery of the implicit rules is more difficult because they are usually outside the awareness of family members, but they are very important. As we observe repetitive patterns within a family we note that they are behaving "as though" a rule existed. A simple, everyday example may be seating arrangements at the family dinner table where, by unspoken agreement, each member has his or her usual seat. The observation that each time the family sits down to a meal the seating arrangement does not vary even though it was never discussed or legislated suggests that the rule exists.

Some issues for assessment of implicit rules include rules for gaining attention, rules for expressing sentiments, especially anger, and rules about togetherness and separateness. Do rules for children emphasize obedience or autonomy? Are the rules consistent, generally agreed upon or a source of conflict? Learning about family rules is important to the assessment. Specifically, the rules governing family interaction patterns are among the important rules to observe for assessment.

Hepworth and Larsen (1986:227) pointed out that an important dimension for assessment of *family rules* is their flexibility or rigidity. Extreme rigidity of rules may make adaptation to changing conditions or advances through life cycle stages extremely difficult and cause disruption within the family. On the other hand, extreme fluidity, to the extent that family members cannot be sure, from day-to-day what the rules are can also be disruptive.

Family role structure: Assessment should determine the family role structure including the roles within the family and roles that members play outside the family group. Since a family system is more than the sum of its parts, roles should be seen as parts that fit together a certain way. They are defined and enacted in a certain way to fulfill needed functions. Role relationships are based on reciprocity and functional interdependence and emerge through mutual adaptation. This is the case whether the emergent structure is positive or problematic. In order to maintain interaction, family members must achieve some congruence in the definition of members' roles.

Within the family there are, of course, the structural role relationships: husband/wife, parent/child, son or daughter, brother or sister, grandparent/grandchild, aunt or uncle, etc. Assessment should attempt to discover how these roles are defined and how they are actually enacted within the family group; are expectations met? Are there conflicts over role definitions? For example, the parent may define the teenager's role as obedient and conforming while an adolescent may be reaching for greater autonomy.

Practitioners should also be alert to cultural and subcultural variations in the definition of these roles. One interesting source of conflict within immigrant families may be between parents' definitions of their roles and adolescents' desires to assimilate and be more like their peers. Some immigrant families also face problems when the parents do not speak English while a child does. The English speaking child gains exceptional power as the one who acts for the family in dealings with various outside systems such as schools, rental agents, social

services, etc. Such a situation can place the parents in an embarrassing and status-diminishing position.

Roles outside the family impinge on family functioning. Assessment should determine the presence of actual or potential role-conflict. The typical example is conflict between the parent role and the worker role. Certainly, the continued well being of the family is bound up with the stability of sources of income. Also, adults' personal identity and sense of self worth are related to performance of their career roles. These may conflict with children's need for care, attention, and involvement with parents. While there are no easy answers here, helping families to improve their functioning may require helping them to develop strategies to deal with such conflicts.

Assessment also involves discovery of emergent roles. Like all social groups, families "create" the roles they need and the roles belong to the group, they are part of the system. One such role is "*legitimizer*." Who in the family must approve before a course of action is undertaken? Another role is "*arbitrator*." Is there someone in the family that mediates conflict among other members? A third role is "*scapegoat*." Is there someone in the family who is blamed when things are thought to be going wrong? A fourth role is that of the "*parentalized child*." Does one of the children take on a parental role with regard to siblings? These and other emergent roles are shaped up in the day-to-day interaction within the family as the family assigns a role to one of the members and behaves in a consistent manner toward that member and reinforces their performance. These roles are assigned to meet some perceived need of the system.

Inappropriate role assignment or role-reversals may take place in some problematic families. Thus, a child may be expected to perform the role of an absent or non-functioning parent and partner. A son may be assigned the role of his mother's male partner with responsibility for the mother's well being. A daughter may be placed in a "housewife" role with responsibility for the well being of the father and siblings. The parent comes to rely on the child for support and to meet some of the parent's needs. Depending on the situation, this kind of role assignment can be overwhelming or confusing for the child who is not equipped to handle the assigned responsibilities. Another consequence may be that the child placed in a spousal role comes to see self as parent's peer which affects the distribution of family power and may create conflict between parent and child as the parent attempts to exercise parental control. There may be additional conflict when the parent attempts to form relationships with age-appropriate partners.

Family power structure: One important set of relationships for assessment is the family power structure. Family power can be determined in terms of who influences whom about what and how. Assessment must reveal who has power, in what areas, and how they use it. Those with power set the agenda. For example, Tony exercises a great deal of power in his family. The family is organized around dealing with Tony and his behavior. More generally, a member may govern the family by their symptoms and problem behaviors. This is systemic, however,

since it takes others to respond appropriately for this usurpation of power to occur.

As with any hierarchically organized social system, families have "order givers," and "order takers." Typically, legitimate exercise of power is assumed by the adults who can be considered "the executive sub-system." In some family settings, the adults are in agreement and act in concert, support each other, and present a unified front as the order givers and generally get the response they want from children as order takers. Problems arise in this context when family members comply with socially unacceptable orders.

Dysfunctional patterns often emerge when the adult or adults abdicate their parental role or allow a child to seize power. Another pattern that may lead to dysfunction may occur when one adult forms a coalition with a child to thwart or undermine the authority of another adult. A grandmother who joins with a granddaughter to overrule the mother's discipline is an example of the latter. Another example is when a natural parent "runs interference" or otherwise prevents a stepparent spouse from exercising authority over a child. Assessment should determine the existence of dysfunctional power blocs and coalitions.

Power relations are also involved in decision making and problem solving. Those with power determine courses of action both within the family and in dealing with the outside world. In families with more than one adult, it may be useful to determine who takes the lead with specific issues such as finances, recreation, social relations, sex, home-making, child care and discipline, and occupational issues. Is decision making shared, are there spheres of influence, and are the partners satisfied with the process? Dissatisfaction may occur, for example, when a member's relative power is disproportionate to his/her their contribution to family resources. The *style* of the exercise of power in decision making is as important as who has the power. Power can be exercised in an authoritarian manner or more democratically. Who is allowed to provide input to problem solving and what influence do they have? Is power exercised directly or indirectly? For example, a family might assert that the father is the decision maker. But his decisions may be carefully guided or manipulated by another member such as his wife or his parents or his children.

The exercise of power helps to maintain the family pattern. Thus the assessment of power in a client family is essential to understanding the functioning of the family.

Family affect: Families are characterized by a range of feelings among and between members. Assessment should determine how family members feel about each other individually and about the family group. One obvious dimension is like-dislike. This can be tricky. A child might reply, "Well they're my parents aren't they? I'm supposed to love them." Or a parent might assert, "I love all the children equally. I don't play favorites." Statements such as these may be firmly embedded in the family's mythic structure but assessment needs to go beyond to determine what is actually the case. Observation of non-verbal behavior among family members can often give clues to their actual feelings about one another.

Another dimension is trust-mistrust. To what extent can family members trust each other on a day-to-day basis? Is there a climate of honesty among members? Do members keep their word to each other? Can they be counted on to follow through on promises made? How secure do family members feel that others in their family will provide support and be there for them? How safe is it for a child to express deep-seated concerns to parents? Do family members fear rejection? The answers to these questions may more than likely come from repeated observations than from direct questions.

Family feelings of cohesiveness, closeness, safety, and connectedness are also important to assess. Often the absence of such feelings contribute to problems as, for example, when an adolescent turns to peer groups or gangs to obtain something that is needed but cannot be obtained from the family. Alternatively, feelings of suffocation and enmeshment can cause members to want to escape from the family setting.

One approach is to look for differences and similarities. What are the differences and similarities in the way a parent or parents feel and express their feelings for each of their children? What are the differences and similarities in the way a given child feels about each of their parents and each of their siblings? Look for differences and similarities and the ways they are expressed. Also, assess the range of feelings expressed. Some families have rules that do not permit the expression of anger, anxiety, doubt or sadness; only calm or happy feelings are permissible. Some families have rules about the expression of affection. For example, some families are emotionally demonstrative while others seem uncomfortable and restrain their emotions.

Family communication: Relationships and processes of families, like any social system, are carried in the communication among members. The basic question for assessment is *who says (or does not say) what to whom about what, in what way.* What are the basic *patterns* of communication in the family?

The communication roles and behaviors that family members display can be thought of as following fairly strict, albeit implicit unexpressed rules, usually outside the awareness of members. However, as they communicate, family members express their views of self and others and express their own perceived status and evaluation of others by the way they talk to each other. Family communication is patterned, not random. George Homan's (1961) formulation of Social Exchange Theory that social interaction is guided by what each person stands to gain and lose from others, is relevant here: the rules and patterns that exist at any given moment have developed over time as the members interact and mutually shape each other through reinforcement.

Watzlawick, Beavin, and Jackson (1967:51) noted that speech can be characterized by both its "content" and "relationship" aspects. The content aspect can be thought of as the idea or intent of the speaker. The relationship aspect refers to how the speaker conveys a perception of self and personal status in relation to the person spoken to. How family members talk to each other–rather than what is said–express liking or not and express whether they feel themselves to be equal,

subordinate, or superordinate to the other. Alliances and coalitions are also revealed in the way members communicate, verbally and non-verbally.

For example, consider family members sitting comfortably watching a TV program. One says to another in a conversational tone, "I'm thirsty, but I'm too tired to move. Would you mind getting me a glass of water, please?" Alternatively, the speaker might turn to the other and snap in a commanding voice, "I'm thirsty. I want some water." The content aspect of both utterances is roughly the same. That is, the response the speaker wants in both cases is the same: to receive a drink of water. But the two utterances also indicate something about the relationship. In both cases, the speaker feels that it is legitimate to ask the other for the service. However, in the first case, the speaker appears to perceive a relationship of status equals by the manner of speech, that the request may cause inconvenience, and is aware that an explanation for the request is necessary. In the second case, the speaker is expressing a view of the other as subordinate and as one whose convenience is of little consequence. The speaker also reveals a definition of self with respect to the other. That is, the speaker assumes that her or his wants place a demand on the other for services (no specific request was made, but was implied).

In general, the content aspect is carried by the words. The relationship aspect is more often carried by word choice, sentence structure, paralinguistic features (rate, pitch, tone, loudness) and non-verbal features (eye contact, facial gestures, posture). Practitioners should observe, listen, and interpret all of these cues as sources of information, generally, and to assess congruence between verbal and actual behavior.

Look for additional cues about family structure from the observation of who talks first, who talks most, who consistently overtops others (speaks when they are speaking or breaks into another's speech), who ignores whom or who changes the subject? Who legitimizes or gives assent to what is said, either by overt approval or silent assent? Who structures interaction or acts as moderator? When a member of the family is speaking, do the others listen? Alliances can be observed in terms of who supports whom and who is allowed to argue with whom and how do the others react to such argument. Role definitions are revealed as members interact. For example, is there a member or members who act as conflict suppressors or mediators or whose interactions are meant to placate dissatisfaction by others?

It is also important to notice who does not speak. For example, in assessment sessions with a family of four, the mother and the oldest daughter monopolized most of the interaction. The father and youngest daughter (who was the identified patient) almost never spoke and when they did it was in response to a direct question or request from either the mother or oldest daughter. For their part, the mother and oldest daughter, age 15, carried on as though they were siblings rather than parent-child. They argued about almost everything and sought to one-up each other. One common topic was the youngest daughter, and the mother's treatment of the youngest daughter. They turned to the father and youngest daughter for support in their conflict. This placed the latter two in an impossible situation of having to support one or the other. Is it any wonder that they tuned out? This

interaction pattern is also an example of what Minuchin (1974:102) called "*triangulation*." The mother and older daughter talk about a third party rather than directly address their relationship. Minuchin called this a " . . . highly dysfunctional structure " because siding with one party invites attack by the other.

Finally, it is important to note non-verbal behavior. While families may attempt to put up a show for the practitioner, their internal states may be more accurately revealed in non-verbal actions. Looks, exchanged looks, eye-contacting, posture, and facial expressions may carry important information. A less obvious non-verbal behavior is the seating arrangement. Sometimes alliances and sub-systems within a family can be revealed by the way the members arrange themselves in physical space.

Program Planning

The program planning stage consists of two parts, the presentation of a formulation and negotiation of an intervention plan. The formulation should present a restatement and analysis of the problem and what can be done about it. The problem may need to be restated in terms of observable, measurable behaviors against which progress toward desired outcomes can be evaluated. To evaluate the effect of intervention requires clear, well-formed objectives. It may also be necessary to restate the problem in terms of several discrete objectives. That is, to solve the overall problem may require a variety of changes. For example, in Tony's case, the program may involve a trial of medication such as Ritalin supervised by a child psychiatrist, placement in special education classes at school, parental involvement in the national non-profit group CHADD (Children and Adults with Attention Deficit Disorders), and changes in family interaction patterns and relationships as well as cognitive and behavioral changes by Tony himself.

The formulation includes the integration of assessment data relating facts to present functioning. It should explain what factors control the occurrence of problem behaviors in context. What are the causes and what function do they serve for whom? Who are the key actors and what part do they play? Family strengths, positive factors and resources should also be included. Finally, the formulation should include options for intervention activities and steps for evaluating progress toward objectives.

It is best to approach your formulation as a tentative hypothesis, and to present it to clients as equal partners facing a shared concern. The discussion permits clients to offer feedback, to comment and make revisions, additions, and amendments to your formulation. By being open with clients and presenting the results of the assessment, you are demystifying the process, not hiding behind a cloak of professional superiority. Instead of maintaining control, you show respect for clients' autonomy, ability to understand and to make creative choices.

Following discussion of the formulation, the next step is to plan the program. This involves negotiating agreement on objectives and steps to achieve them. Negotiation of objectives sometimes involves a choice-point for both you and

clients. For example, one objective may be that the client will have to abstain from alcohol use. He may decide he does not want to stop drinking even though other objectives are contingent upon abstinence from alcohol. He may withdraw or he may state his willingness to work on some other objective, such as anger control, but not quit drinking. This attitude may need to be addressed as an intervention issue or you may eventually have to decide whether you are willing to continue with this client under these conditions.

The program plan itself is a statement of who will do what, when, where, and how, with target outcomes specified. From negotiation and consensus over objectives, the discussion with clients should turn toward negotiation and contracting for the specific action steps. Here the practitioner's role is to explain the options for interventions, their reasons, and possible outcomes, both positive and negative. Explanations should be geared to clients' understanding. They should be able to understand the relevance of the options and have an opportunity to provide input and to make choices about what is relevant for them in their context. It is often useful for the practitioner and client to collaborate to develop a written plan that includes the objectives, activities, target dates, and specified roles. It is important to negotiate role performance. Lane (1990) pointed out that it is not the practitioner's task to assign what role others will play, but to find out their preference and negotiate acceptable roles for work.

The intervention program should be individualized, not a matter of fitting clients into problem categories and following a prescribed routine of treatment. Each client's context is unique. The task of program planning is to enable clients to develop strategies for change, to add constructive choices to their behavioral repertoire. That is, the goal of intervention is to help clients add constructive choices to their present behavior. Presumably, identification of a need to change indicates that some behaviors are maladaptive. Problem behaviors persist because clients are unaware of alternatives, or if aware, lack the skill to use them, or if aware and skilled, lack incentives to use them. Program planning will need to consider the inclusion of resocialization experiences and include work to overcome barriers that prevent clients from adopting alternative strategies. Intervention should increase the likelihood of more adaptive strategies for behavior change.

In program planning at the microlevel, pay attention to the three major action systems: biological, psychological, and social. Assessment should have revealed the contribution of each to the problem. Biologically, the use of medication or other medical procedures, changes in diet, or fitness and health promotion activities may be relevant. Some or all of this may be outside the scope of a sociological practitioner and collaborative relations with appropriate professionals such as physicians, nutritionists, or health educators is essential. Psychologically, assessment should have revealed cognitions, feelings, and ideas associated with the problem as well as features of clients' personalities and cognitive styles. Some members of a client system may have identity issues associated with the problem behaviors. Assessment should also have revealed the presence of psychopathology. Socially, attention is directed to relationships and interactions. Since primary relations with significant others have the greatest influence in socialization, they

can be of key importance in resocialization as Bryan (1992) pointed out. More generally, problem behaviors are often associated with role performances. Program planning may need to address specific role performances and relationships.

Decisions about the prioritization of biological, psychological and social aspects of a client's problem are a matter of professional judgment with input from clients. For example, a client who has chronic chest pain may also have personal and familial relationship difficulties; the two conditions may interact with each other. The best approach in problem solving may be to find a physician to deal with her physical condition as a first priority, or to deal with her medical and psychosocial problems simultaneously. The same may be true in medically stabilizing a person with a chronic mental disorder, or addressing dangerous eating disorders such as anorexia or bulimia, or helping substance abusers detoxify, or counseling a person who has attempted suicide.

Program planning must pay attention both to the *intra*personal and the *inter*personal aspects of action. Action is mediated by the internal dialogue, cognitive events that include the client's internal representation of the situation, of self and others, of own and others roles, and expectation of outcomes that can be obtained in the situation calling for action. The client's motives include protecting self and one's evaluation of self and either maximizing reward or minimizing punishment to self.

Approaches to Program Implementation

All action, including problematic behavior, is patterned and is caused. For change to occur the pattern must be disrupted and new behaviors in context must be established. Behavior is in response to some set of antecedent conditions and is maintained by its consequences. For change to occur, intervention must address the chain of antecedent conditions that bring on the problem behaviors, the behaviors themselves, and/or the consequences of the behaviors that keep them in place. The creative task is to determine where in the sequence to intervene, the locus of intervention, and how to intervene.

Assessment should also direct attention to the locus/loci of intervention, the place or places at which to direct change efforts. The concept, locus of intervention, refers both to where in the sequence of events and where in the client's world

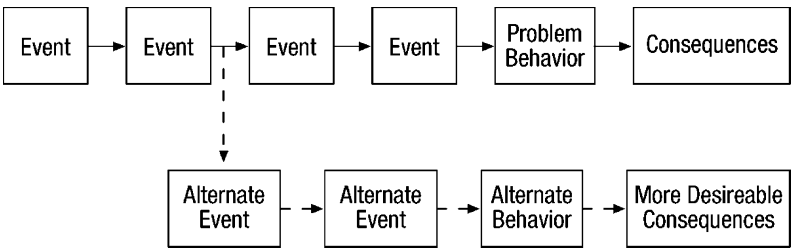

FIGURE 3.5. Disrupt Sequence of Antecedent Conditions

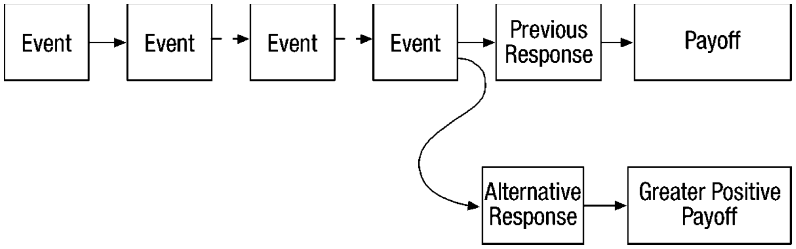

FIGURE 3.6. Response Change

to work for change. The sequence of events refers to the antecedent---> the response---> the consequences. Figure 3.5 shows one possible approach, the disruption of the sequence of antecedent conditions.

The sequence of antecedent conditions may include contexts, interactions, cognitions, feelings, and behaviors. The earlier in the sequence that redirection can take place, the better. The key to making this work includes making sure that the client can execute the new response and that the new response is more rewarding than the previous response.

Where this approach is not possible, attention turns to the problem behavior itself and its consequences. Figure 3.6 illustrates the intervention works to shape a new response to the old sequence and works to establish more desirable outcomes than were previously received. In either case, for new behaviors to be *tried*, clients must anticipate more positive outcomes. For new behaviors to *replace* previous behaviors, they must provide more positive outcomes.

The development of strategies for helping people change requires an understanding of the personal and social context for change. We agree with Roger Straus (1982), who noted that behavior and our sense of self reflect social arrangements. Individuals are not passive responders, but are creative constructors, "doing the best they can to meet their conditions of existence and trying to create a relatively stable, meaningful, and satisfying life for themselves and those with whom they are closely bonded." Each person must conduct their daily lives as actor and as an object for their own evaluation, what George Herbert Mead (1934) termed the "I" and the "me." We all take part in many networks and must interact with a variety of others. We try to emerge from these transactions with situations, self, and others with an intact sense of positive self-worth and perhaps, having achieved some worthwhile objectives. Behavioral choices, which depend on interpretation of the situation, are made to meet these goals.

The individual is not an empty vessel, but approaches the interpretation of situations and the selection of behaviors by applying prior leanings. This learning serves as a predictive base; action is chosen within a defined situation based on anticipated outcomes which are derived from this predictive base. Learning, experiences, growth, offer us the opportunity to enrich our predictive base and add alternative behavioral choices. We change or refine behavior on our own to improve our outcomes. We often seek to change when older, established patterns no longer get us

the outcomes we want. In such a situation we may experiment with new strategies until we find out what works for us. This is not always possible for everyone, however. Experimentation is only possible when the person perceives that the cost of failure is relatively low. The situation and surroundings may make predictability more desirable while experimenting with new behaviors, whose outcomes are unknown, produces anxiety, something to be avoided.

To change, we must be open to change, growth, and experimentation. Sometimes, change is difficult for people. If nothing else, our present actions, strategies, and presentations of self may have relatively predictable outcomes in terms of coping with our everyday tasks and relationships. Our present strategies may not be the best possible, but they have the feature that outcomes are relatively well known while the consequences of new behaviors may be unpredictable. Change can involve a great deal of risk and feelings of ambiguity, fear, and stress, depending on the circumstances. These feelings might be strong enough for a client to choose a temporary predictable problem solution over a solution that holds the promise of being permanent but requires a longer-term commitment to change.

People consult practitioners, either voluntarily or involuntarily, when time does not support their continued search for a solution to their problem, or when they have exhausted their own resources, or otherwise feel their backs are to the wall. For change to occur, people must become aware of constructive alternatives, be able to use them, and they must believe that they will reliably and predictably lead to better outcomes.

Choices for action also involve taking the role of the other. Behaviors are chosen based on the real or anticipated actions of others. Members of ongoing groups, such as families, generally have developed a predictive base about the likely responses of co-actors. Present behavior represents the actor's perception of the best adaptation to the situations calling for action. Change by an individual group member has consequences for others and the individual's relationships with others. An individual's present behavior may be maintained by the outcomes obtained within a relationship or set of relationships such as occurs within a group or family. One of the risks of new behaviors may be the loss of a relationship or important payoffs within the relationship. Change by an individual may also require adjustments by others and the way they relate to and interact with this person.

Practitioners must be aware of an individual's social networks. Change by an individual member may threaten to upset the stable structure of a family or other social network. Long-standing role relationships with the individual, that others found comfortable and predictable, may be disrupted, or the individual's attempts to change may be threatening to others. Change by the individual may result in punishments or the loss of valued rewards previously obtained from these social relations. Thus, members of a client's social system may be sources of barriers to change. Change by an individual may be resisted by others who exert pressures that work against the individual's attempts to change.

Practitioners must be aware of these negative processes and attempt to counteract them. One step is to educate the individual client about the process, explaining how it works and why. As systems theory suggests, change by one

member of a social system ultimately means change by the other members and the system as a whole. Working with key members of the client's social system, preparing them for the consequences of the client's change, and enlisting their support for the client's change efforts can also be important steps in facilitating an individual's change.

This will need to be handled with careful planning and sensitivity. For example, family members may feel that an individual member "owns" the problem and therefore is the one who must change to improve the situation. They may find it difficult to understand and even more difficult to accept that their own actions toward the individual may contribute to the maintenance of the problem behaviors and that they may also have to change to facilitate improvement in the identified client. Such change also will have to have some positive payoff for them.

Programs for change, then, must proceed on a broad front that includes the internal dialogues of individuals and their interactive behaviors within situations. With regard to the former, the practitioner's task could be to help clients understand the role their internal representations play, the content and sources of their present thinking, and helping clients find and use more positive thoughts that are appropriate to their background and situation and may result in improved outcomes. John Glass (1992:114–115) described just such an approach in work with adults raised in alcoholic homes. Of this approach Glass wrote:

> Initially, an individual can benefit from education and elucidation about how painful thoughts, emotions, and behaviors can arise through interaction with family members, i.e. how self is formed. This helps the individual to understand the origin of these painful phenomena, and also makes clear that the thoughts, emotions, and behaviors are all subject to change–the internalized 'truth' about self can be challenged. The individual can engage in the redefinition of self. With this information, the individual is able to begin the process of self-resocialization–intentionally replacing negative self-images, attitudes, and behaviors with more positive, life-affirming ones.

Programs must also address the social aspect, the interactive behaviors of members of a client system. Billson (1994:128) stated that:

> Practice for sociologists lies in intervention in problems relating to **interpersonal processes** as they appear in **patterned interaction** among individuals **in groups** of all sizes and types. The primary goal of such intervention is to modify **interpersonal behavior** and to ameliorate the negative aspects of **external conditions** that affect interpersonal processes. (Emphasis in original)

As individuals develop more effective ways of communicating and interacting, they may be able to negotiate more positive relationships and they may also develop a more positive sense of self as a result of having more positive consequences from social interactions. For example, changes in dysfunctional interaction patterns among family members can have far reaching consequences for all members. Minuchin (1974:91) expressed this view in his formulations of structural family therapy. He stated that "Change is seen as occurring through the process of the therapist's affiliation with the family and restructuring of the family in a carefully planned way, so as to transform dysfunctional transactional patterns." Role-playing sessions with clients are a useful tool here. It gives the

practitioner an opportunity to teach and help members learn new behaviors. It allows them to experiment with these new behaviors in a relatively risk-free setting and allows for rehearsal to develop some skill and comfort with them.

As much as possible, intervention programs should concentrate on changes occurring in the contexts where changes are identified as necessary. Conversations and sessions in the practitioner's office may fit everyone's model of "therapy," but they serve little purpose unless they apply to real behavior changes and problem solutions in clients' own life spaces. We believe that, as best practiced, sociological practice is not completely a chair-bound, office-centered activity. Subject, of course, to negotiation and contracting with clients, the sociological practitioner may play several roles in working toward behavior change and problem solution. And, sociological practitioners must be prepared to "go where the action is."

Thus, in addition to office sessions, a sociological practitioner working with a child such as Tony may make school visits to work with school staff on interaction with the child. This may involve providing an in-service training for school staff on topics like conflict mediation or coaching specific individuals on how to conduct a behavior modification program for a specific child. It may involve work as the child's advocate to obtain special education or other resources from the school or other organizations and agencies. Intervention programs may also involve coaching family members on alternative interaction patterns and ways to communicate. This might include the practitioner modeling alternative behaviors then asking family members to rehearse them to help them learn how to do them.

The practitioner's task is to assist clients in altering their internal dialogue. In addition, the practitioner's task is to help clients learn problem solving strategies when again faced with a need to change. From the perspective of individual members of a client system, this means developing alternative responses to familiar situations that will provide better payoffs. To do this, clients must be able to explore new role definitions and role performances and be able to rehearse them in a situation of little or no risk. From the perspective of a total client system, such as a family, members must acknowledge the reciprocal aspects of role relationships and be able to facilitate each other's attempts to change and renegotiate their relationships.

Program Implementation and Evaluation

Program planning should result in contracting for the intervention activities including specification of who will do what, when, where, and how. It should also specify target dates and evaluation procedures. Program implementation involves carrying out the agreed upon steps. Program evaluation involves monitoring progress toward the objectives.

The evaluation phase points up the application of the scientific methods of sociology, what Mark van de Vall (1987) called "*data based sociological practice*." The

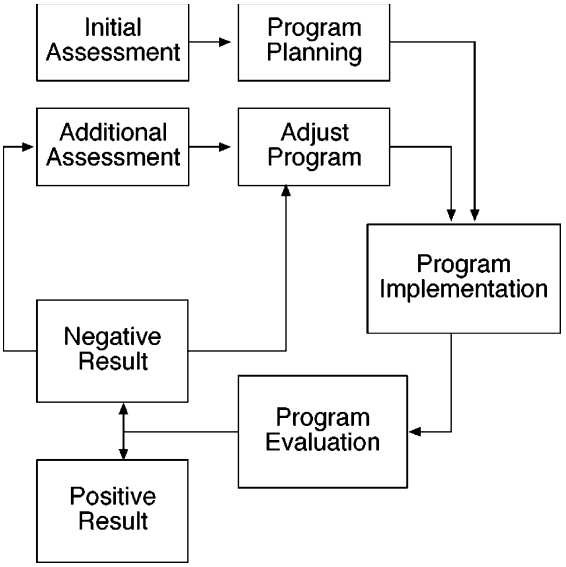

Figure 3.7. Fitting Program Evaluation into the Intervention Process

intervention plan is analogous to a hypothesis to be tested. Continuation with or modification of the plan depends on data collected concurrent with implementation.

Our discussion of the intervention steps–assessment, program planning, program implementation, and program evaluation–has, of necessity, been presented in linear fashion. In reality it is not a linear but a circular process.

Figure 3.7 shows how evaluation fits into the process: Data from the evaluation may show that the program is working as planned and moving toward the desired outcome (Positive Result). In this case, the decision is to continue with implementation as originally planned. However, data from the evaluation may show that the program is not proceeding as planned or is not showing movement toward the objective (Negative Result). This may require additional assessment data and/or an adjustment to the program, implementation of the adjusted program, and continued evaluation.

Earlier, we suggested that objectives can be subdivided as process objectives and outcome objectives. Process objectives are statements about activities to be undertaken. Process evaluation consists of making sure that planned activities take place when and as planned. Often, practitioners, especially beginners, focus on results and neglect process evaluation. This is not the best strategy. A program is designed that is hypothesized to achieve movement toward a certain outcome. Failure to achieve that outcome may be attributed to the program itself. But that may not be the case. If the program was not implemented as planned, it has not been adequately tested.

Process evaluation should be included in the evaluation plan. Data should include whether the steps were taken as planned and in the sequence and time

frame planned. Process evaluation may also reveal bottlenecks or barriers to implementation of the planned steps. This may require a return to the assessment stage or the planning stage and further negotiation with clients.

Process objectives are to be stated as measurable variables. For example, process objective may be stated as:

1. John will enroll in the county GED program by (give date) and attend 3 classes per week.
2. John will take the high school equivalency test by (give date).

Monitoring these objectives can be as simple as having the instructor sign an attendance sheet each session that John attends.

Outcome objectives are also to be stated as measurable variables. Leitenberg (1973) offered a plan for "controlled investigation of single cases." They depend on operationalizing, observing, and quantifying both problem behaviors and target behaviors. Without considering each design in detail, generally, baseline rates of behaviors are established prior to intervention then measured following the introduction of the intervention that is hypothesized to bring about the desired change. If the rates of problem behaviors do not change following the introduction of the intervention, it would seem clear that program changes are in order.

A simple example of an outcome objective might be:

Tony will attend school 90% of the time by (give date).

Given that Tony's present rate of attendance, the baseline rate, is less than 50% of the time, such an objective represents a positive change. It is clearly measurable with a bit of cooperation from either parents or school personnel. (Obviously, attendance alone would not constitute all the objectives for Tony but would be one among several appropriate to the problem. The others must be equally measurable.)

We agree with Leitenberg that this approach is different from the usual uncontrolled case studies where a practitioner applies "professional judgment" on whether an intervention is working or not. The components of this approach involve establishing clear and specific criteria for success and systematic collection of quantifiable data which can be compared to established criteria. It permits more accurate and objective judgment of the intervention steps.

Summary

Sociological practice is applicable to the problems of individuals and families seen as micro-level social units. Attention is directed not only to intra-individual processes but to social relationships and interactive behaviors as well. In addition, sociological practice on the microlevel must maintain an awareness of the interplay of levels–the influences of mesolevel and macro-sociological processes on individuals and families. Problems are defined in terms of problem behaviors and problem solving emphasizes behavior change. Intervention is guided by empirical processes including thorough data gathering for

assessment and evaluation of operationally defined and measurable outcomes. Practitioners are also guided by humanistic values that show respect for clients' uniqueness and autonomy.

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4
Problem Solving at the Mesolevel

Introduction

This chapter turns to sociological practice on the mesolevel. Many sociologists have viewed the distinctions between micro and macro as merely analytical, that they are abstractions, that they are not reality (Berger, 1963; Berger & Neuhaus, 1977). Turner (2005) disagreed. He considered micro and macro levels as social reality and added the mesolevel. He asserted that the social universe operates at micro, meso, and macrolevels; social "reality" includes all three levels. Turner also believed that the social forces operating at the micro, meso, and macrolevels differ. They generate and then operate within particular kinds of structures.

At the macrolevel the structures generated by social forces are *institutional systems* which are broad-based, extensive, multi-layered networks of roles and norms that serve broad functions. Political-legal systems, educational systems, or economic systems are examples. At the mesolevel, the social forces generate *corporate or categorical systems* such as organizations and communities. And, at the microlevel, the social forces generate *intra-* and *interpersonal systems* within primary groups. Turner wrote that "the structural units and forces driving their formation and operation constitute the social universe; the goal of sociological theory is to develop principles on the dynamics of each force as well as on the relationships among forces" (Turner, 2005: 410). We concur with Turner. We have developed this chapter on meso or middle-range social forces, which we encounter frequently in our practice and application of sociology. In this chapter we will focus, primarily, on organizational development and community organization as mesolevel intervention.

The Mesolevel of Sociological Practice

At the mesolevel individuals come together to form large social structures such as organizations and communities. The nature of these larger social structures is influenced by individuals as they interact and negotiate their social reality. However, this negotiation is influenced by the situation. The social setting presents a structured situation in which individuals' behavior becomes patterned by

expectations, role definitions, organizational boundaries, leadership, and other contextual factors. For example, families who move into a gated residential community must join the homeowner's association. They become voting members. They agree to pay dues, to follow the rules of the association, and to elect their leaders. Another meso example would be the "community" that emerges when students enroll in a university's Internet course. Students do not interact face-to-face and are geographically dispersed. Individuals who are members of virtual communities share a common interest, may or may not meet face-to-face, and exchange words and ideas through the mediation of computer networks. People chat. They argue. They plan, make friends, even fall in love. They do everything people do when they meet face to face, but by computers, separated in time and space. In these examples, social constraints affect individuals. There are expectations, boundaries and time limitations. As Collins (1988:412) stated:

> Human beings have the capacity to create or negotiate whatever they can at any moment in time. But they always act in a structured situation, so that the consequences and conditions of their creativity and negotiation are nevertheless patterned by larger relationships beyond their control.

People experience *society*, the macrostructures, in interaction with specific others. It is here we find the mesolevel. Mesolevel structures have in common the fact that they provide people with their everyday experiences. Mesolevel structures include a variety of organizations and social networks such as neighborhoods, neighborhood institutions, gangs, clubs, public agencies, corporate businesses, boards and even Internet chat rooms. They provide everyday roles that often become intricately linked with our identities and meet a variety of needs beyond those met by family. We usually receive our education and health care, vote, work, engage in political or religious activity, and often make our livelihoods as members of organizations. Berger and Neuhaus (1977) characterized mesolevel structures when they discussed "mediating structures," structures small and close to individuals that mediate between them and larger social, political, and economic forces including bureaucracies (Couto, 1989:15). These structures mediate between, and connect, the macrolevel and the microlevel. Mesolevel structures often deliver and/or interpret the macrolevel for individuals and families at the microlevel.

Mesolevel structures may vary in size, scope, time-frame, degree of bondedness, and degree of concreteness. For example, a public school system within an identified district, a school within that system, and Mr. Brown's third grade class could all be characterized as mesolevel structures. The school and the class are subject to influences and constraints from the macrolevels, the larger society, the state, the state's educational setup and from the school district itself. As mesolevel structures, the school and the class affect each child – microlevel – in Mr. Brown's class. The example illustrates mesolevel structures as mediators and illustrates the interaction of levels as well.

When we leave home for work, we move from the micro to the mesolevel. We encounter more and different social forces. Our attitudes and our behaviors change as we move from one level to another. The nature of our interactions with people, their expectations of us, and the way we spend our time also change. In

moving from the micro to the mesolevel, daily life becomes more complex. As we enter the workplace there may be macrolevel influences – competitors, market forces, or world events – that affect our job. Microlevel events are also always a present concern. While at work there may be an emergency at home that we have to leave work to deal with. We are continually engaged with micro, meso, and macro concerns. When conflicts arise between these levels and interfere with our ability to perform our usual roles, we need to call upon our repertoire of adaptive skills.

Organizations and communities are two types of mesolevel social structures that come to the attention of practitioners. In the next sections we will consider a general view of each of these, then turn to consideration of intervention.

Organizations

Sociological practice at the mesolevel is, most frequently, practiced within an organizational context. Collins (1988:450) remarked:

> Most social issues in sociology are organizational problems. Deviance, police, corrections, medical sociology, educational problems, ethnic and gender discrimination, as well as the largest-scale issues of citizen control of the military, environmental degradation, industrial accidents, nuclear war, and the operation of democracy, are all largely organizational problems.

An organization is a group of people intentionally organized to accomplish an overall common goal or set of goals through a division of labor. Business organizations, for example, are formed to deliver goods or services to consumers to realize a profit. Government agencies exist to carry out some function established by statute. Social and civic voluntary associations and community organizations are created to support or provide a variety of human services. These objectives define the "work" of an organization. To do its work, an organization develops a structure, a recurrent and more or less predictable pattern of relationships among members that results in coordination of members' activities, and maintains the organization as an intact unit.

Organizational Survival and Adaptability

To visually understand the application of the input-process-output model to organizations, the reader may want to consult Figure 2.1 in Chapter 2, as the following discussion unfolds.

Organizations are open systems, which means that they interact with their internal and external environments. The environment of a system establishes its boundaries or the conditions that act on and interact with its focal system (Anderson, 1990). Boundaries exist for all organizations. They are the constraints that the organization must contend with. They include laws, statutes, and regulations that govern the provision of goods and services. The realities of a global

economy and global competition are also examples. As environmental demands change, organizations must be able to continuously adapt in order to survive.

As organizations define their boundaries they also define the types of relationships they would like to have with other systems. Organizations receive a variety of inputs or demands from other systems. Inputs are ideas and activities that cross organizational boundaries and affect organizations in various ways, such as in collaboration. For example, Sun Microsystems Laboratories, which has parts of their organization at three different geographical sites, studied how geographic separation affected organizational boundaries, level of trust, and motivation to work together of employees at these sites. They found that by teaming employees across sites that they could take greater advantage of expertise at all three sites. They formed ad hoc employee teams on an "as needed" basis to deal with complex customer problems that tended to cross group boundaries. Sun Microsystems learned the importance of asynchronous collaboration and group knowledge in meeting customer needs.

Another example of system inputs across organizational boundaries are virtual teams. Organizations are able to leverage expertise that is dispersed over geographic areas and broaden experience by working across organizations and cultures. Virtual teams are agile and can be formed quickly, but they are also more complex to manage. With the increasing international presence of many organizations, distributed teams are becoming necessary to reduce organization costs and enhance operating efficiencies. The frequency of mergers, acquisitions, downsizing, and technical specialization are additional structural changes that are requiring organizations to cross boundaries (Trautsch, 2003).

On the other hand, organizations do not blend together easily, as every organization has its own history, vision, mission, and structure. Organizational uniqueness can be an asset, but it can also further organizational separatism and isolation. Inputs can be in several forms including information, material, services, and activities. Inputs enter an organization, are responded to and acted upon by members to carry out the objectives that promote the continuation of the organization. Outputs leave the organization also as information, material, services, and activities. Outputs become part of the external environment that feeds back as input to continue the organizational cycle.

As organizations change, their boundaries usually are modified. This does not always happen easily or rapidly, as studies of mergers have shown. The more rigid the structure of the organization, and the more controlled the work of its members, the greater the difficulty in modifying boundaries. Alderfer (1976) suggested that either "overbounded" or "underbounded" organizational structure may have difficulties. Underbounded systems, that lack clear, consistent boundaries, often face issues of survival, while overbounded systems lose their flexibility and ability to adapt.

For example, consider a 600 bed community hospital. Inputs include patients, the capital necessary to obtain diagnostic and treatment technology, hire personnel, and purchase supplies. They also include the time, knowledge, skill, and energy of the workforce. Orders for products such as beds and medicines are also

inputs. Environmental inputs such as the supply of nurses, availability of beds, accessibility of consultant physicians are also inputs. Market forces affect the patient census and the affordability of care. Other examples of inputs include the policies and plans of other nearby hospitals, technology, regulations, conditions in the labor force, and outside controls such as government, accreditation bodies, new laws and health care cost reimbursement. The hospital's continued existence is dependent on its ability to output services to its external environment so that it receives as feedback a continuous flow of inputs that support its existence. The hospital's well-being depends largely on its profitability.

The input-process-output model also applies to public agencies or service organizations. Usually, the objectives and methods of operation of public agencies are established by statute. Some or all of their operating funds come from legislative appropriation. Like the hospital, public and service organizations develop their structures influenced by the environmental parameters and their work. Inputs include the resources necessary to carry out their mandate as well as demands for services from a clientele and other environmental conditions. Their survival also depends on receiving continuous support from their environment.

In the division of labor, various positions are organized as subsystems. Perhaps the hospital's main subsystems are patient care and marketing. Each of these may be composed of sub-sub-systems. For example, a marketing division might be composed of departments such as customer relations and market analysis. These sub-sub-systems may be further divided into specific work or project units responsible for various functions, with workers in each unit – managers, medical staff, nurses, secretaries, etc. – responsible for specific tasks and contribute to the overall objective of the organization. System analysis for problem solving requires specification of the focal system, which defines the system elements and its environment. Thus, for a department within a division, the elements of the system may be the workers in various positions. The environment includes other departments. If the division is the focal system, the departments constitute subsystems.

As each unit at each level operates, they process the inputs from the environment with a goal of meeting the objective to maintain its continued existence. The concept of "steady state" as it applies to organizations needs elaboration. First, the concept denotes a dynamic, not a static state. A steady state refers to ongoing negotiation with an environment to survive and maintain stability; maintenance of a steady state means coping effectively with ongoing threats to survival and stability. Ashby (1956:197) used the metaphor of a cat pursuing a mouse to illustrate the concept. The mouse, as a dynamic system can be in a variety of states in its attempts to escape from the cat. Some of these states are consistent with the outcome: "mouse survives." However, other possible states of the mouse do not correspond to "survival."

Some states are consistent with survival and stability and others are not. For example, a community organization that keeps taking on projects and activities tangential to its main purpose and objectives will strain its resources and become overwhelmed with new environmental demands, threatening its overall effectiveness and survival. Ashby noted that there are what he called "disturbances" that threaten the stability of a system. There are many types of disturbances. Ashby said that the

task of an organization is to translate these disturbances into outcomes that are consistent with the goals of the organization, and ignore others. This process Ashby called "regulation;" it is an integral part of the ongoing life of an organization.

Regulation involves processing the variety of disturbances or inputs from the environment into a mode or state that is consistent with the organization's survival and stability. Organizational environments establish the conditions to which organizations must adapt if they are to survive. The more complex the environment, the greater the diversity of potential inputs or disturbances and the more complex the organization has to be to cope with the variety.

Application 4.1 illustrates these points by discussing how individuals in an organization cope with the stages of a merger over time. Organizational mergers present a variety of disturbances for the organizations involved. Because mergers are often not well planned with input from the affected employees or members, mergers are frequently unsuccessful and create a negative internal environment for the organizations involved.

APPLICATION 4.1 How an Organization Coped With a Merger

The work of Mel Fugate, Kinicki, and Scheck (2002) have provided insights into how individuals in an organization cope with the stages of a merger over time. Corporate mergers are interventions into the life cycle of an organization, and, as such, provide an opportunity to study the person-environment relationships and negative effects to which employees and employers must adapt.

Data were collected from a national organization in the aerospace industry. A survey was administered in four waves, each approximately three months apart, to employees from one of the plants. A computer generated a random list of 1,800 employees; every sixth employee was sampled, deriving a sample of 300. The first survey was administered one month after the sale of the focal organization, the *anticipatory stage*. The second survey was given three months later, the *initial change stage*. The third survey was administered three months later during the *final change stage* and the fourth survey was given in the *aftershock stage* nine months after the merger was first announced.

The findings were that social support is an important coping resource throughout the stages of a merger. The availability of social support declined during the most uncertain and stressful stages of a merger as people coped between the anticipatory time and the final stage. It was then replenished during the aftershock stage. This pattern reinforced the conclusion that social support was an important coping resource that changes over time in accordance with shifts in a specific person-environment transaction. Management may want to design merger interventions that focus on replenishing the coping resources of social support. This can be done through employee assistance programs, town meetings where employees can voice their views openly among themselves and/or management.

One of the key findings from this study has relevance when evaluating the effects of an intervention in an organization, that is, it is important to study how individuals cope with change over time in order to capture the true nature of the coping process. Mergers are an intervention; they put people's livelihoods at risk and they also leave employees powerless to effect change or control their situations. Available social support resources can assist employees in coping with the effects of the merger. This can apply to other types of organizational interventions where reinforcement and supportive resources can affect the eventual outcome of an intervention.

Steady State

The concept of steady state in organizations can have several meanings, but generally it refers to survival and stability. Survival and stability are not necessarily synonymous. Problems may arise in an organization when its stability is threatened. An example is "group think." Group think occurs when members of the organization place the maintenance of group solidarity above task effectiveness. Members of the organization may overtly agree on an issue or policy though they hold private their unvoiced reservations. A group norm of avoiding conflict to maintain stability can cause problems for the group. Another example of an organizational problem is when an individual or group within the organization protects themselves by failing or resisting to comply with formal rules. Some organizations are able to maintain stable patterns of behavior even though these patterns may be maladaptive. Problems arise when these patterns become disruptive and inhibit the organization from meeting its overall objectives. Problem solving needs to address both the organizational structure and the situations that are creating a problem.

One way organizations help to maintain their steady state is to set goals, and establish structures and practices that will ensure continuity in the organization. While the bottom line in many organizations is profitability, Collins (1988:461–462) observed that the organization will continue as long as its hierarchy remains intact and continues to pay employees, not whether it is successful in meeting its objectives. He stated that:

> Ultimately it is the control structure that determines whether and in what form the organization will exist. Functional task pressures may feed into this, but as a secondary influence.

Moreover, how task-effective an organization has to be depends on its environment. An inefficient organization may continue to exist if the environment supports it. On the other hand, a public agency that does not have the support of the majority of its governing legislative body will have a short life, despite its level of effectiveness.

For organizations to maintain a steady state, control and regulation are necessary functions. Environmental conditions as inputs must be processed in such a way that the organization's response as output promotes the well-being of the organization. Control and regulation processes attempt to organize the internal activity to meet input demands and maintain existence. Organizations establish formal systems of control and regulation through a hierarchy of positions. Certain positions have authority over the responsibility for the activities of others and for coordinating those activities. The hierarchy is also the formal communication structure as certain positions report to and receive orders from certain higher positions. Problem solving may need to assess the legitimacy and appropriateness of the hierarchy given the task of the organization.

Control and regulation involve decision making on methods for coordinating the components and meeting environmental conditions. This involves correcting internal conditions that may have become dysfunctional or responding to changing external conditions and demands. Market changes, technological change, changes in statutes and governmental regulation, all require that the organization adapt so that conditions are met with responses that maintain the organization's well-being and profitability.

Problems arise for an organization if it does not or cannot adapt to limit the threats to its integrity. Control and regulation can be either reactive or proactive. Reactive regulation is "error" driven and involves responses to problems that have occurred. Proactive regulation involves anticipating challenges to the organization and planning appropriately. Britt (1991) has argued that a proactive stance heightens organizations' ability to cope with challenges to their well-being.

Organizational Structure

Organizational structure is defined by the distribution of power and the mechanisms used for control and coordination to realize organizational goals. The structure is shaped by the work which, in turn, is shaped by the goals which are defined by interaction with the environment. A clothing manufacturing plant will have a structure that is very different from that of a public mental health outpatient clinic. The two types of tasks represent points on a continuum from highly routine, predictable, and repetitive tasks with standardized outcomes to tasks that feature a high degree of uncertainty requiring professional training, initiative, creativity, and adaptability and whose outcomes are difficult to specify.

Organizations can gain compliance through coercive control, through manipulation of material rewards, or through voluntary, internalized acceptance by members of the organization's goals (Collins, 1988; Etzioni, 1975). Administrative procedures, that is, the methods used to gain compliance, are adapted to the work. Administrative devices can be categorized as: (1) surveillance, (2) inspecting outcomes, (3) written policies and procedures, (4) information control, and (5) environmental control. Surveillance involves posting "watchers" to see what workers comply. It is likely to produce minimal compliance primarily when the observers are present. Inspecting outcomes involves situations with easily measured outcomes but focuses on the product, not the process. Compliance is limited to the measurable

outcomes. The use of written policies and procedures is an attempt to rationalize performance but focuses on procedures rather than outcomes. The presence of rules may lead informal groups to evade the rules. Informational control is based on the ability to define the situation such as having "expert" knowledge or skill. The greater the uncertainty in the environment, the greater the control those in possession of specialized information can exert. Environmental control can be exercised by controlling the physical setting to limit noncompliance.

Control and Coordination

The use of control-type and administrative devices establishes the organizational structure and responds to the goals and work of the organization. For example, if the task is the assembly and sale of fast food, tasks of low initiative with observable outcomes, coercive control, surveillance, rigid rules, and environmental control will work very effectively. This is especially true if there is no need to counter alienation or to have workers internalize the goals of the organization. The availability of an endless supply of teenage workers helps to make up for the high turnover rate of employees in the fast-food industry (Ritzer, 1993). On the other hand, with tasks that call for initiative and creative adaptation to relatively unpredictable situations, such as the work of most professionals, administrators, or emergency workers, coercive controls are not likely to be effective. Surveillance, rules, piecework, and other coercive measures eliminate worker autonomy which can be alienating, fail to motivate, and not meet the needs of the situation. Internalized control and informational administrative procedures are more likely to be found with these tasks.

Any organization may have a mix of control and administrative procedures. Workers at the lowest level in the status structure may receive more coercive control while the organization may count on internalized control for members in higher statuses. Although there are qualifications, the general principle is that "organizations which choose the proper form of control for its tasks will survive and prosper" (Collins, 1988:464). One qualification is the nature of environmental demands; how efficient an organization has to be may depend on its environment. However, an organization's choice of the "proper" form of control is itself a result of control and the exercise of power within the organization.

The task and the structure, however, cannot be divorced from the environment. The goal is framed in terms of the production of goods and/or services to output to the environment. The structure must be responsive to the nature of the demands or disturbances in the environment. As noted above, the structure must be of sufficient complexity to meet complexity in the environment. The key to understanding an organization is to understand its work and how it organizes its work given its environmental constraints.

Organizational Change

Change is an inevitable aspect of organizations. Some change is created by the organization and other change occurs with the passage of time. Organizations change because external forces interacting with them change, creating new demands.

Organizations change internally because leaders and managers change, members' behavior changes, and because organizations grow and develop along their life cycles. Organizations attempt to maintain a steady state. Coping, growth, and survival all involve maintaining the structural integrity of the system in the face of change that causes disequilibrium. The set of shared assumptions that develop over time in organizations serve as a stabilizing function. An organization's culture also helps to preserve its integrity, identity, and autonomy (Schein, 1992). Schein reminded us that, at different stages of an organization's culture different possibilities for change arise because of the particular function that culture plays at each developmental stage. He pointed out three organizational cultural states, namely, *founding and early growth, midlife*, and *maturity and decline.*

Organizational change may be minor or major, affecting parts of the system and the total organization differently, and creating enough disequilibrium to create a motivation to change. The social psychologist, Kurt Lewin (1958), called the motivation to change, "*unfreezing*." Unfreezing existing behavior must occur before change can occur. Once an organization has been unfrozen, the change process can occur. Organizational change necessitates the need for behavior change. Some organizations and its members resist change and, as a result, delay in restoring a new equilibrium to the organization. An organization that never fully adapts to specific sets of changes, and accumulates the experience of unresolved change, may be faced with its demise. A healthy organization, on the other hand, is one that interacts with, responds to, and benefits from various changing environmental demands upon it.

Sociological practitioners are asked to consult with organizations when they are healthy and unhealthy. They assist organizations with cross-cultural and cross-boundary issues during times of growth and globalization as well as provide guidance to human resources departments on problems involving inequities and group conflict, especially during downsizing and mergers. The majority of organizations must deal with the effects of change at some time during their life cycle. One of the most common problems in organizations is managing boundaries in the face of change.

Boundaries

Boundaries separate an organization from its environment and identify the parts and processes within the organization. Boundaries also determine the nature of interactions within the organization and between organizations. Therefore, boundaries need to be flexible yet clearly defined. Boundaries protect organizations. Social change continually tests boundaries. Problems usually arise in organizations when there are either excessive or insufficient boundaries (Schneider, 1991). Insufficient boundaries create overlap and redundancy. Excessive boundaries, on the other hand, may be so rigid that they produce the "it's not my job" attitude. Excessive boundaries fragment organizations.

During downsizing, acquisitions, mergers, hostile takeovers, and joint ventures boundaries need to be redrawn and redefined. The organization has to adapt to a

new steady state. This process often results in much anxiety about the new distribution of power and control. Boundary change affects all sub-systems, and sub-sub-systems in an organization, but the leader must establish the boundary between what is inside and what is outside in order to preserve the integrity and the internal coherence of the organizational system (Shapiro & Zinner, 1979).

Schneider (1991:187) stated, "boundaries within and between organizations must be considered subjective and not objective. All boundaries are *perceived*; they cannot be taken as given." Therefore, one of the major assessment tasks of the sociological practitioner asked to consult with an organization undergoing a significant structural change is to address the question "what is the nature of boundaries in the organization and how does autonomy and control relate to their management?" During periods of external threat, change, or re-organization, turf battles and fragmentation of effort may be "the problem" presented to the sociological practitioner for advice and assistance.

Schneider (1991:185) suggested three categories of issues to address when consulting with organizations. These are:

- *Help differentiate*: clarify boundaries by identifying and defining roles, structures, functions, and units; determine "niches" of competence in relationship to the total organization; develop an understanding of where, when, and how to gain and preserve autonomy and clarify areas of interdependence.
- *Help integrate*: clarify key tasks; determine necessary interdependencies; develop an understanding of the distribution of power in the organization; promote the ability to negotiate boundaries.
- *Help design structure and processes that facilitate organizational goals*: enable interdisciplinary teams to perform their required tasks; encourage leaders and members to identify problems early and to establish mechanisms for input into how problems can be prevented from recurring.

Organizations are now increasingly viewed as networks, that is, linked competencies or areas of specialized expertise on a global scale. This requires greater and greater efforts to maintain the dynamics of boundaries with clear autonomy and control.

Another aspect of the structure of organizations that is tied to change is the organizational life cycle and socialization.

Life Cycle and Organizational Socialization

Tichy (1980) said that organizations do not follow predictable biosocial stages of development because the laws of social systems are not the same as those of biological systems. However, there is agreement that organizations have life cycles, irrespective of their size and complexity, and share some common experiences as they move from point to point in the process of growth and development.

Authors differ in their views of the stages or phases of organizational life cycles. Quinn and Cameron (1983) suggested four stages. Stage 1 is the *entrepreneurial stage* with an emphasis on marshalling resources, planning and coordination, forming a

"niche" and entrepreneurial activities. Stage 2 is the *collectivity stage* in which a sense of mission is developed, innovation continues, and there is a high degree of commitment and a sense of collectivity. Stage 3 is the *formalization and control stage* in which rules are formalized, the structure is stabilized, institutional procedures are developed, and the emphasis is on efficiency and maintenance of the steady state. Stage 4 is the *elaboration of structure stage* in which the organization undergoes adaptation, renewal, expansion, and decentralization. Schein (1992) proposed three broad organizational stages: founding and early growth, midlife, and maturity and decline. There is little in the published literature about organizational decline and death, instead the focus is on regeneration, revitalization, and rebirth.

Obviously, organizations change as they progress through their respective stages of growth and development. While there are expected milestones to be met at the various stages of development for all organizations, the timing and ways in which organizations move from phase to phase is unique. The length of time an organization has existed is less important than what it has accomplished vis-à-vis its purpose and goals. Every organization experiences some problems at some tine in its life cycle. Some organizations thrive on change, others try to avoid or ignore it, still others become stuck or overwhelmed because of the unexpected effects of change.

Sociological practitioners who are asked to consult with organizations frequently find that change issues are at the root of the presenting problem. An assessment of an organization's life cycle can readily be obtained through behavioral observation and informal interviews with organizational leaders and members. Table 4.1 provides a list of ten questions to assist in operationalizing the life cycle. Answers to these questions should provide some insight into the strengths and weaknesses in the socialization process of an organization.

Table 4.1. Operationalizing the life cycle.

1. What is the history of the organization; especially circumstances of its founding and initial structure?
2. What are the perceptions of the accomplishments of the organization given its purpose and goals by leaders, members, and outsiders who interact with the organization?
3. What do organizational leaders see as the next stage of development for the organization and the issues to be dealt with? Is there consensus?
4. What do leaders, members, and outsiders see as obstacles or barriers of the organization's further progress?
5. What are the current tasks facing the organization? Is there excitement and optimism about the organization's future?
6. What do leaders and members perceive their responsibility to be to the development of the organization? What have they done and what are they willing to do?
7. How does the developmental stage of the organization relate to its decision-making, power structure, empowerment of members?
8. Does the organization have a mechanism or procedure to anticipate and prevent problems?
9. What are the leaders' and members' plans to promote the organization's healthy growth and development?
10. What are the communication patterns in the organization? Attitudes toward change? Aspirations for the organization?

Community Organization

"Community" means different things to different people. We speak of the community of nations, the community of New Orleans, the gay and lesbian community, the Microsoft community, the Greek community, the Princeton community, the African American community, the virtual community and so on (Putnam, 2000). Each of us derives a sense of identity, social support, and feeling of security by belonging to a community. For most people, the deepest sense of belonging comes from our family, work, church, and civic and social life. As social animals it is important that we stay connected with others. This is why immigrants usually form communities when they settle in a new environment; to commune with others who have similar values, beliefs, and cultural traditions, provides a safety net, a degree of comfort and security in a larger environment of strangeness and uncertainty (Bruhn, 2005).

In the history of the United States communities have been "places." With social change, acculturation, assimilation and a growing societal emphasis on accepting diversity as a value, communities of "place" have been decreasing in size and disappearing. It is a question for debate whether "communities of place" are being replaced by virtual communities and technologically created social networks. Putnam (2000) presented convincing evidence from national surveys and polls conducted from 1960 to 2000, that social mobility, urban sprawl, technology, generational differences in values, and decreased trust have contributed to the shift away from communities of place. Communities of place, which most younger Americans have never known or experienced, are treated with nostalgia. Despite efforts by developers to create suburban communities of place, and an emotional appeal by sociologists such as Amitai Etzioni (1993), to join a national communitarian social movement to restore community values in our changing society, communities of place are gradually disappearing as the generations of World War I and II die off.

Community organization often involves the development of a fairly formal organization, usually in response to shared problems facing the members of a community. Rivera and Erlich (1992) had ethnic minorities in mind when they defined community organization as:

> Efforts to mobilize people who are directly affected by a community condition (that is the 'victims,' the unaffiliated, the unorganized, and the nonparticipating) into groups and organizations to enable them to take action on the social problems and issues that concern them. A typical feature of these efforts is the concern with building new organizations among people who have not been previously organized to take social action on a problem (Rivera & Erlich, 1992:3).

By community organizing we refer to methods of intervention in which a professional change agent helps community members, groups, or organizations organize for planned collective action for social change. It may be to address a particular single issue or it may be to develop unity to address a wide range of problems and community needs: maintenance or improvement of physical facilities such as parks, street or sidewalk paving, housing, street lighting; initiation or

improvement of services such as police, sanitation, or fire protection, health and welfare or education; political and economic issues involving policies, legislation, and distribution of resources; social problems such as drug use, crime and violence, teen pregnancy, discrimination and ethnic conflict.

Community organizing activities vary depending on the nature and needs of the specific community. There may be strong, close ties among members at one extreme to none at the other extreme. Community members may be an advantaged group or may be oppressed, powerless, and disadvantaged or some mix. They may be keenly aware of their problems or have no awareness. In general, community organizing involves helping community members create a relatively formal structure, an organization, with the ability to work toward achieving some defined set of goals. Often this involves confronting a power structure of some sort. The view is that by acting through a formal structure of their own, community members can, to some extent, redress the power imbalance between them and formal power structures.

Roles for community organizers can be labeled "enabler," "broker," or "activist." In the *enabler* role, the community organizer works directly with a client population, not as a leader but to help facilitate the efforts of local people. In the enabler role, the community organizer tries not to provide answers but may raise questions that help local people gain insights to the problem. The role occupant does not accept responsibility for organizing but encourages the local people who actually decide what to do.

A second role is that of *broker*. In this role, the community organizer negotiates with networks that local people have little information or experience with. The broker also puts people to touch with resources. In the third role, the *activist*, the community organizer takes direct action to organize people and to confront and challenge opposition. Which role to adopt depends on the situation and the orientation of the organizer. In many instances, community organizers may engage in each of these roles in the course of their work.

Just as community needs vary, approaches to community organization and change vary as well. Rothman (1979) developed three models as pure-types while noting that they often overlap. The three models or approaches were labeled "*locality development*," "*social planning*," and "*social action*." In Rothman's analysis, the goals for intervention and the nature of the community suggest different approaches to change as well as different roles for the change agent.

In the first model, *locality development*, the goal is to organize the community into an integrated, functioning unit with change based on involving " . . . broad participation of a wide spectrum of people at the local level in goal determination and action." The idea is that, for change to take place, individuals first must come to see themselves as a community and learn that, through consensus building and collective action, they can address and often solve problems within their locale. The change agent's role is that of enabling, encouraging, and facilitating community members to organize. The role may also involve teaching and facilitating group process and teaching problem solving skills. Confronting power structures may not always be the goal in this model. Often organizing and creating a sense

of community can be goals in themselves, which may later be applied, effectively, as needs arise, to work internally or to negotiate with outside agents.

The second approach, *social planning*, features a technical approach to solving specific social problems through "rational, deliberately planned and controlled change . . ." The change agent's role is that of expert planner who applies expertise to design and implement plans and policies in a cost-effective manner. Participation by community members may vary from a little to a lot; the emphasis is on the technical skill of the expert including the ability to obtain desired responses from bureaucracies.

In the third approach, *social action*, the change agent takes an activist role to organize a disadvantaged community as a conflict structure to confront a power structure, such as government, for social justice and/or redistribution of power and resources. This is the Alinsky model of community organization and change. John Glass (1984) pointed out, Saul Alinsky (1941/1984) believed that change comes through power, the ability to act. For the powerless, this means organization.

Rothman and Reed (1984) described mobilizing a community to assess its needs and create an effective plan to address drug and alcohol problems. They noted that communities vary in the extent to which they regulate and support types of drug use. Even experts on drug use and abuse differ on the definition of the problem. Community variability and scientific uncertainty make it presumptuous to prescribe uniform interventions. Just as there are many approaches to intervention in drug and alcohol problems, there are various ways for sociological practitioners to help communities organize to do something about them. One approach was reported by Watts (1989); Watts and Wright (1991) endorsed the view that the community level presents opportunities for change, " . . . greater than at the societal or individual levels." He used both qualitative and quantitative research to bring drug problems to the community's attention leading to mobilization. Watts' activities exemplify the locality development approach. He also called attention to another point relevant for a discussion of community organization. As the intervention agent, Watts' work led to the definition of youth drug use as a social problem where previously it had not been recognized as such. If an individual's abuse of drugs and alcohol disrupts the individual's life, that is a personal problem. However, it is a social problem if the pattern exists within the community. Watts noted, "The sociologist can help alter community beliefs that contribute to an environment that tolerates drug use." Watts' work introduced the issue of teen drug use into what Hilgartner and Bosk (1988) called "The Public Arena."

Hilgartner and Bosk rejected the view that social problems are readily identifiable and have an objective reality. They argued that " . . . social problems are projections of collective sentiments rather than simple mirrors of objective conditions . . ." Social problem definitions evolve in "*arenas*" where a situation or condition gets labeled as a problem "*in the arenas of public discourse*." Arenas include the mass media, both news and entertainment, political organizations, social action groups, religious organizations, professional societies, or anywhere people come together on an institutional basis. These arenas are competitive market places where public attention is a scarce resource.

In addition to the competition among problems for attention, competing interpretations of a problem may exist. A problem such as drug use or teen pregnancy could be interpreted as problems of individual responsibility or as social and community problems. Community organization to address a problem calls for dramatic activity on many levels to bring the problem to community attention and to develop a shared collective definition that a problem exists and needs to be addressed by collective action. The various arenas in which problems may be addressed, however, have a "carrying capacity," a limit on the number of problems that can be attended to at a time. Timing entry into the field should be included in any strategy.

Hilgartner and Bosk also noted the principles by which social problems are selected for appearance. The *first* is "drama;" *the more dramatically the problem can be presented, the more likely it will compete successfully*. Problems must remain dramatic requiring the introduction of new symbols or events from time to time. *Second, problems couched in broad cultural themes compete better. Third, problems framed in terms acceptable to dominant political and economic groups will compete better. Finally, each organization has its own rhythms that influence the timing of its attention to social problems which also affects selection*. These include, for example, reporters' and editors' understanding of what is news.

For community organization efforts to be effective, community members must define a problem, believe collective action will be effective, and be prepared to give their time and energy to the collective effort. Watts' work in his community accomplished these objectives by dramatically illustrating that a problem existed, that it was a social problem that touched each family, thereby encouraging mobilization.

Mesolevel Intervention

The task of a sociological practitioner in organizational development or community organization, is to work with members of a social system, " . . . to help them to change social structure or modes of functioning or both." (Jacques, 1982). It is important to emphasize that social problems must be addressed socially. Because problems appear to be manifested in the behavior of individuals, problems are often addressed by attempts to modify the behavior of individuals judged to be deviant, to "have a problem." Managers and administrators tend to have an individual orientation consistent with our cultural beliefs in individualism. It is also easier to contemplate changing individuals than broad structural and institutional patterns and processes. Finkelstein (1992) concluded that, in most efforts at addressing social system problems, "the primary unit of analysis remains the individual."

Finkelstein referred to individual and social psychological analyses as restrictive and too narrow. He was critical of "narrowly focusing on the attitudes, beliefs, and subjective states of individuals in order to predict behavior." Individuals are active creators of reality, but they construct their reality collectively and adapt to their social systems as best they can. Attitudes and behaviors, motives and motivations, beliefs, values, and commitments are constructed and

maintained by social processes within social systems. Feelings of alienation, frustration, and powerlessness derive from social structures, social, political, and economic processes, and individuals' roles and status within social structures. These feelings must be addressed if social change is to be lasting and effective.

For example, a high school finds a segment of the youth unreachable and unteachable, into drugs and delinquency, and generally incorrigible. Well-meaning individual interventions may include disciplinary action, behavioral management, individual treatment plans, and counseling and tutoring. These often end in frustration since they fail to examine and address the structure and culture of the school, the community, neighborhoods, peers, and families, and fail to involve the total social system in addressing what are social rather than individual problems. The situation calls for multilevel analysis. Intervention is an attempt to close the gap between what is and what ought to be. Preparing for change involves what we have called the strategic steps of intervention: Assessment, Program Planning, Program Implementation, and Program Evaluation.

People with problems want solutions. When faced with a problem, the temptation is to start generating solutions and adopting one. The danger in this approach may be failure to address the right problem and/or adopting strategies that will not work. Sociological practitioners bring a more deliberate and rational process to problem solving. As we have stated, problem solving requires change. Change requires preparation (See Application 4.2).

APPLICATION 4.2 Homeless Campus in Phoenix

Intervention at the mesolevel is illustrated by the new homeless campus in downtown Phoenix, Arizona. An estimated 10,000 to 14,000 homeless live in Maricopa County. At any given time 700 of these individuals gather in downtown Phoenix in search of water, food and shelter. In November, 2005 a metropolitan wide approach to the city's homeless was launched. To improve the coordination of services for the homeless and at-risk populations, a Human Services campus was opened as part of a regional approach. The county committed 14 acres in downtown Phoenix to bring together five agencies that serve the city's homeless. The $15 million campus also includes an emergency shelter, a clinic, dining facilities, and a day resource center to provide workforce development services to assist people in obtaining employment. The campus represents a unique collaborative effort among faith-based, private, non profit, governmental, and community organizations to provide better service and security for those requiring assistance. Funding was a joint effort between several charitable foundations, the county and the city. The major goal of the campus is to offer a continuum of services at a single location to coordinate communication and services between agencies, thereby reducing barriers to accessing multiple services and increasing the overall engagement of homeless users in the services the campus will offer.

Homeless campuses also exist in Reno, San Diego, and Miami. San Antonio has a temporary services center with plans to develop a permanent one. The mall concept or "one stop service centers" is a national trend, yet in some communities, such as Cincinnati, the Zoning Board turned down a proposed services mall. Finding the right location for centralizing the urban homeless remains a barrier to serving them.

Preparation for Change

Preparation for change begins with assessment. Assessment involves analysis of a social problem, its nature, and importance. Analysis of a social problem includes the application of sociological methods to the analysis of a social system. It means gathering detailed information on the problem, the social system, and the social system's relationships with other relevant social systems. Assertions are supported by data which define the problem and point toward design and implementation of a program for problem solving. Analysis of social systems involves analysis of structures and processes. It means working with members of a client system to construct a knowledge base regarding the social system and its problems.

Content of Assessment: Many of the principles expressed in Chapter 3 generalize to mesolevel cases and bear repeating. The first item for your assessment is whether to take on the task. As before, relevant issues include the demands on your time, your expertise, and your interests. Value issues are also relevant. If the goals are incompatible with your values, it may be best not to become involved. There are some issues you may want to evaluate before getting involved. These issues may affect whether you want to get involved or at least guide the way you proceed. Often you must decide on the basis of a brief contact with a representative of the client system. Is commitment to change genuine? Some organizations may find it useful merely to appear to be addressing problems. Are you being asked to help "cool out" pockets of discontent rather than genuinely address problems and circumstances that generate legitimate criticism? Are there hidden agendas? Is a business organization's goal to gain tighter control and manipulation of employees? You may also want to evaluate how much control those in authority will have and how much freedom you will have to pursue your investigation. Is the intervention being imposed by those in authority or is there general concern and willingness to address problems? In this section we propose a participatory model of invention that involves all levels of a system. If you follow this approach it may also be necessary to discover if this is acceptable in this client system.

An important early step is to identify the focal system, the social unit with the problem. This permits further identification of various system levels – sub- and sub-sub systems, and supra-systems. It also directs attention to boundaries, mapping linkages with other systems, and identification of the relevant environment and the constraints it presents. Finally, it permits identification of the level of

analysis. It is important not to confuse system levels. The general principle is that a system must be analyzed at its own level; that is, a system must be analyzed in terms of the interaction and relationships among its elements. No amount of analysis of system components will reveal the nature of a system. This is not to say that analysis of sub-systems is not useful. It does mean that, at any level, analysis of components will not explain the unit. Analysis of the interaction and relationships among elements is essential to understanding a system.

If a division composed of several departments is the focal system, analysis of the division means analysis of the structure and interaction of the various departments. Analysis of each department as subsystems may also be necessary for a complete understanding of the problem, but the division itself can only be understood in terms of the relationships among its components. The size and complexity of the focal system is a key variable governing the assessment and all stages of the intervention. Multilevel analysis is essential.

Begin assessment by eliciting a statement of the presenting problem. As Ramondt (1994:93) observed:

> The clinical approach attaches particular importance to the preliminary investigation, which sets the framework for determining which problems are to be examined. The predominant culture in organizations is not a problem-setting but a solution-oriented one. In many cases this is the major source of problems within an organization; the problem has not been properly identified and poorly defined solutions are tackled.

As is often the case, the problem statement may eventually have to be refined or even reformulated, but clients' accounts represent their understanding and represent what they want you to understand about their situation. Clients' statements of the presenting problem may be a socially constructed reality derived from the interaction network and influential members within it. It may be widely shared by members of the client system. As an element of organizational culture, the shared definition of the problem may affect broad areas of action within the organization and frame attempts to cope with or solve the problem.

Alternatively, an issue for ongoing assessment may be to determine how widely shared this statement of the problem is. It may be useful to keep Murphy's Law in mind: "Where you stand on an issue depends on where you sit." What some may define as a problem may be a coping mechanism for others. It would not be unusual in a formal organization for upper management, middle management, and workers to have very different views on what the problem is, who is responsible, what needs "fixing," and how to "fix" it.

It is not useful to try to find out who is "right." Do not try to reconcile, merge, or average the different points of view. Within any given social system there are cliques and interest groups. Interests may vary across organizational levels and across sub-systems. It is useful to observe where consensus and differences exist in problem definition.

A historical approach to problem analysis is sometimes useful. Often social systems' problems have their roots in processes and structures that were once quite rational and effective or were designed for conditions that have changed or

no longer exist. More generally, problems often evolve over time; small quantitative changes in response to environmental demands may emerge as the major qualitative changes that have become problematic. Historical analysis may provide understanding of how long the problem situation has existed and how it came to be recognized as a problem. It may also reveal causal factors, though it is important not to oversimplify. Problems seldom have a single cause. Finally, historical analysis may show what has been tried previously to alleviate the problem and what effects these attempts have had including the responses of members of the social system to attempts at problem solving. Ramondt also suggested exploring critical incidents in an organization's history, the way in which they were handled, and the consequences.

Social problems exist because some group defines a condition or situation as deviating from some norm or desired state. For organizations, created for explicit purposes, deviation may include those things that contribute to reduction in goalward movement such as reduced productivity or the things that threaten stability. For communities, deviation may include those things usually defined as socially deviant – crime, drugs, violence, – or quality of life or standard of living issues.

Problem analysis should discover what official norms govern behavior. Official norms derive from sets of values and perhaps even determinations of morality. Assessment should uncover these. Analyses should also determine the extent of deviation from the norm. This calls for data on the extent of the problem as well as data on the social and economic costs. Organizations may show reduced productivity, employee dissatisfaction, poor morale, and problem behaviors. A school system may show a high dropout or failure rate or instances of weapons being brought to school or instances of violence. Communities may show high rates of violence, crime, and drugs as well as physical deterioration or unattended health or mental health problems of residents. Data on the extent of the problem and its social costs can be an aid to mobilization of problem solving activities. For example, we previously showed how Watts' (1989) data on drug use identified a social rather than an individual problem.

Problem analysis should further locate the social causes of social problems. Emile Durkheim's "Rule" (1893/1966) is still valid: social facts should be explained in terms of other social facts. Social problems are the consequences of social arrangements. The input-process-output-feedback model suggests an approach. It is necessary to identify the important variables that describe the input. However, the issue for analysis is the process; how does the organization organize to do its work? Ramondt argued for analyzing organizations in terms of their organizing behavior and what they *do* rather than what they are. This reveals the relationship between structure and process. It was also Ramondt's view that structure must follow the process.

Analysis of the task structure includes analysis of the task itself. What is to be done and how is it to be done? How are tasks organized, coordinated and controlled? Who has the responsibility and who has authority over what specific operations? As they emerge from the work, attention to other structures is necessary. Specific structures include the communication structures, both formal and

informal: who talks to whom about what, when and how? The power structure is another: What are the formal and informal influence, authority, and reward structures? What positions have the responsibility for what decisions? Questions for assessment also include the following: Who are the key actors, both individuals and groups? What are the control, coordination, and regulation mechanisms in organizations? Who are the decision makers and legitimizers? What is the nature of power relations? What are the processes of power and control? How do they work? How is power and influence distributed within the system? What are the formal and informal structures and how do they operate? How do their goals, norms and values differ? Are there needs for training and personnel development? Do members have the resources including the ability necessary to carry out their roles? What are the communication styles and patterns? How does the system manage conflict and tension, planning and goal setting? How are decisions arrived at? What is the pattern of social relations? Are persons mistreated?

Additionally, French and Bell (1984) presented a list of assessment questions for formal organizations:

- What are the organization's norms and values?
- What are the attitudes, opinions, and feelings of members toward system goals, management, procedures, etc.?
- What is the internal climate? Authoritarian or democratic? Oppressive or open? Controlling or trusting?
- How effective are the organization's procedures for monitoring and preparing for oncoming or potential problems?
- How do sub-systems relate to the whole? What are the unique demands placed on each sub-system? How do they interface and are there differences in their performance levels?
- Are sub-system goals compatible with system goals?
- Do members know how to do what is expected of them?
- Is good use made of resources?
- What are intergroup relations like and what effects do they have on the overall system?
- How does the system interface with its environment and with other systems?

Much of the above applies when the object of intervention is community organization. The analysis must include the problem, the environment, the structure of the social system, and the possibilities and readiness for change. Like assessment with organizations, assessment of communities should locate power, influence, and authority structures. Additional questions for assessment include, what is the nature of the community, the demographic characteristics? What naturally occurring networks exist? What, if any, interest groups exist and what is the nature of their interaction? Do their interests conflict? What are their concerns? What are the communication networks and where are they? Who are the gatekeepers and legitimizers within the community? Where are the rallying places where people come together? What are the outside agencies that impact on or provide services for the members of the community and what are relations with them? What socio-economic

and political issues exist within the community? What are the cultural norms and values that guide the community, for example an ethnic community?

Saul Alinsky's report (1941/1984) of community organization in the Back of the Yards Slum area in Chicago around 1940 serves as an example. Community members determined that chronic social problems existed: unemployment, disease, child welfare issues, delinquency, and poor housing. They also determined that the solution to their problems depended on themselves. Demographically, the Back of the Yards area had great ethnic variety. Though 90% were Roman Catholic, each ethnic group had its own church. Most community residents were economically dependent on the Stock Yards as well. Through organizing efforts, the church and organized labor managed to bring the diverse groups together and became central organizations in providing leadership and legitimacy for community organization. The result was the Back of the Yards Neighborhood Council, rooted primarily in the fundamental institutions of the community: whose members had "a vast fund of intimate knowledge regarding those subtle, informal, and personal aspects of the communal life of Back of the Yards." Through this Council, the problems of the community were addressed with many positive achievements.

An assessment of a social system is conducted from within it. the rules of good research should govern the assessment task. Various research strategies can be used as the following list suggests:

1. Survey research with structured questionnaires and rating scales have the value of covering a large organization or community and developing useful data quickly and efficiently. Panel studies or repeated waves can be used to monitor trends and other aspects of the time dimension.
2. In-depth interviews with selected role occupants at all levels of the system can also be useful to flesh out details that questionnaires often miss.
3. Focus groups with members sampled across levels of a social system can also be useful to get more in-depth insights into members' views and concerns. The method has the advantage of allowing contact with more respondents than one-on-one interviews and is an efficient use of time.
4. Specific meetings with a whole team or work unit or other intact-group within the social system can be useful to observe the functioning and interaction patterns of the unit.
5. Both participant and non-participant observation can provide data on actual activity in the naturalistic setting.
6. Review of documents, policy statements, plans, budgets, evaluations, mission statements, and tables of organization, documents usually available with formal organizations, can be an essential step. They represent formal statements of what ought to be that can be compared to how things are actually done. Are policies and procedures rational and consistent? Do they facilitate achievement of desired outcomes?
7. Monitoring the flow of communication, both written and non-written, can also be useful. Observe both the formal and informal networks. How is information

disseminated and how effective are the existing networks? Where appropriate, include mass media in the analysis.
8. Diaries and record keeping by selected members of an organization can also be a useful source of information. For example, one technique involves having members record their activities at random intervals.

The Process of Assessment: Participatory Research. The process of assessment is a research task designed to reveal the structure and processes of a social system, help define and clarify the problem situation, and point toward pathways for change. It differs from scientific research in its intent and often in its methodology. The practitioner cannot take the role of a disinterested scientist. The goal is to produce positive social change. The methodology we offer here was labeled "action based" by Finkelstein (1992). Couto (1987) called the approach "participatory research" and Whyte (1989) called it "participatory action research" (PAR).

The technique recognized the dynamic nature of social change. That is, neither the intervention agent nor members of a social system can control all the factors influencing change. In addition, as change begins, secondary changes may occur that may alter the change process itself. Change is not likely to be brought about by simply introducing a sequence of planned activities and letting them take their course. The change process needs continual guidance by people able to adapt creatively to reach the desired outcome. Whyte (1989:368) stated, "Success in organizational change is not achieved simply by making the right decision at a particular time but rather through developing a social process that facilitates organizational learning."

Couto's model of participatory research seems to have community organization in mind. He stated that "Its central concerns are research, knowledge production, and empowerment related to the position of oppressed people, poor people, people with political or economic disadvantage." The intent is to mobilize people affected by a problem, with research and action both part of the change process. Couto indicated the characteristics of participatory research are as follows:

- The problem under study and the decision to study it have origins in the community affected by the problem;
- The goal of the research is political or social change derived from the information gathered;
- Local people control the process of problem definition, information gathering, and decisions about action following from the information; and
- Local people and professional researchers are equals in the research process. They are both researchers and learners (Couto, 1987:84).

In this model, the role of the sociological practitioner is to maintain constant dialogue with, train, and assist local people to conduct and use credible research that clarifies and documents the problem and clarifies what needs to be done to solve the problem.

Whyte (1989) applied what he called participatory action research (PAR) to organizational change and problem solving. In this approach, professionals work

together with organizational members "in designing projects, gathering and analyzing data, and utilizing the findings in action projects." By their participation in the process, organizational members and decision makers control and own the change process by shaping it to their needs.

Whyte (1989:374) said the "research design is a joint product" of professionals and organization members. The latter "carry a major responsibility for gathering and evaluating data, and serve as . . . the experts on technical matters . . ." related to the work of the organization. "The professional researchers assume responsibility . . . for helping [organization members] integrate the socio- with the technical to develop a socio-technical model of the change process." Whyte went on to argue, quite persuasively based on his extensive experience, that effective organizational work must integrate the social and the technical systems:

> Since the social system shapes ways in which technology is developed and applied, and the technological system shapes and channels social relations, analyses that focus on only one of these two systems are bound to be theoretically misleading and of limited practical value.

Putting PAR into practice involves assembling a research team drawn from the various components of the focal system. Organizational members of the team should represent the technical expertise relevant to the work of the organization. Sociological practitioners can assist through group facilitation, and providing information on the operation of social systems as well as providing training and advice on research methodology. The process involves ongoing dialogue among all members of the team, both organizational members and sociological practitioners.

Planning for Change

Change is a process. Some change will occur with or without intervention. But if change is to be directed and controlled, it must be developed. Therefore, an intervention should involve a carefully crafted plan about the direction and speed of change, and how change will affect the members of the social system following the intervention. Responsibility for the effects of an intervention should be acknowledged and accepted by all parties involved in the effort.

The assessment research should provide an analysis of the problem, the social system, and what needs to be done to bring about change that solves problems. The next step is the planning of an intervention program. The intervention program can be viewed as having five major needs: 1) conceptualizing and developing the parts of a change effort; 2) preparing a strategy designed to get change accepted; 3) implementation of the strategy; 4) follow-up to determine whether or not the strategy worked; 5) ability to adapt based on these findings. The most consistent aspect of sociological intervention is that it is data-based. An intervention plan is based on a thorough assessment of the problem situation and the social system. Progress is monitored throughout implementation through ongoing evaluation both of process and outcomes. The fourth and fifth parts are often neglected in the overall plan or the intervenor leaves the field before effects can be assessed. Sometimes change may be slow and cumulative and therefore it may be impossible to observe

any obvious effects in a short period following the intervention (Netting, Kettner, & McMurtry, 1993). However, every effort must be made to monitor an intervention program so that guidance of the process, step five, is based on evidence. Planning must include an evaluation plan.

Preparing for change should include assessment of a system's readiness for change. Not all members of a client system will conceive of change the same way or even see the need for change. Change may mean new role relationships, changes in formal or informal status structures, or changes in interaction patterns. Change may mean a new task structure. Members may also come to feel their security is being threatened. Some will see change as a threat to stability and resist. The intervention agent, whether inside or from outside the system, must be careful not to impose change, to do so could result in anger, hostility, and resistance. It is important to learn attitudes toward change, the sources of support and resistance, and the values and priorities of the target of intervention. It is possible that the time is not right for intervention and change, but it is essential that a consensus for change arise and be supported; that intervention not be imposed. Program planning involves negotiation and consensus building with regards to goals as well as means.

Interventions can be one-time only or take place over time; they may occur more than once over time and in more than one way. Some interventions require little or no effort on the part of the recipient(s) while other interventions need substantial time and commitment; e.g. completing food diaries, interviews, and tests. The nature and duration of interventions must be made known to the members of the client system. Furthermore, it is advantageous for the intervenor to get input at periodic intervals. This will help insure an open and trusting relationship and assist in retaining people in the intervention effort.

Preparing for change requires that the intervenor carefully conduct an assessment that includes a group's prior experience with change, attitudes toward change, and the group's perception of what needs to be changed and their degree of investment in bringing about change. Imposed change will bring about opposition and hostility. Preparation for change requires time, patience, and touching base with those who will be affected by change. The best situation is for the targets of change to participate in helping bring it about.

Preparing for change may also involve what Ramondt (1994) referred to as an *analysis of a social system's capacity for change*. This refers to the energy and resources available to apply to a change process and what else is competing for the use of these resources. Ramondt further suggested that analysis of capacity for change should recognize critical domains within the social system and how much energy is invested in each domain:

- The political domain: Who decides and who cooperates with whom in the allocation of scarce resources.
- The cultural domain: To what extent does consensus exist on norms and values relating to key policy areas.
- The technical domain: What is the "design of the central processes for realizing a desired output."

In some instances analysis of readiness for change and capacity for change may lead to the conclusion to hold off. However, in most cases they should be viewed as affecting the change strategy. Knowledge of readiness and capacity for change in a social system may affect the timing of various steps. It may show the need for efforts at persuasion and influence or negotiation and compromise with various constituencies to get key actors "on board" so that further movement can take place. All too often resistance and other barriers to change are attributed to individuals. However, analysis of readiness and capacity for change should include the structural factors of a social system that produce individual member's attitudes towards and participation in change efforts.

Change efforts in organizations should focus on the work and the process by which the work is done. The social organization, as Ramondt (1994) stated, should be compatible with the design of the process. Planning, implementation, and evaluation of change efforts should be based on a real partnership between the professional change agents and the organization members. Sometimes a show of participation is used as a manipulative tool to gain compliance, but organization members' experience, knowledge, and skills with the organization and the work are an important resource. If they are given a real role to play in the change process, the design is more likely to address needs and they are more likely to have the motivation to carry out the activities to make it work.

Program planning, therefore, continues the collaborative effort that includes the sociological practitioner(s) and system members to produce what Whyte (1982) called "social inventions" which focus on outcome objectives. For organizations Whyte described the PAR approach in which "the social scientists structured the social and technological learning process." Organization members from a variety of positions – managers, supervisors, workers, union leaders, etc. – worked with the social scientists "in designing new physical, technological, and social organizational arrangements." The social scientists shared control of the process with key organization members.

This approach to organizational problem solving is often called "sociotechnical" to emphasize the close association between the technological aspects of the task and the social organization of the task-process. Policy and program development must consider both aspects. As Whyte (1989) described PAR, organization members had the responsibility for gathering and evaluating data and providing technical expertise on matters pertaining to the task. The social scientists helped organization members "integrate the socio- with the technical to develop a sociotechnical model of the change process."

Program planning must also consider how, when, and where implementation will begin the steps for transition. Where appropriate, pilot programs may be useful. Finally, program planning must establish the evaluation procedures. It must establish measurable process indictors which will determine whether the plan proceeds on course as planned. Outcome indicators must also be established to determine if the plan moves the organization toward the objective. Evaluation should also be alert for unintended negative effects. Time frames should be established for deciding whether to continue a course of action or to consider modification based on the results of evaluation.

Planning for change in community organization work is a collaborative activity to achieve a goal that is mutually defined, that is, the goals and the steps to achieve the goals are established by active, ongoing involvement of the people affected by the process. The sociological practitioner participates as a member along with the community members. The plan to be developed should specify what and how it is to be done, by whom, when, and why.

Planning must begin with consensus on the goals, the desired outcome for the community. This itself may not be a simple task. The more diverse the community and the more diverse the interests of the various constituencies, the more the need for negotiation, compromise, and consensus building. The systemic nature of all social systems reminds us that any change affects all components of a system as well as the total system. Planning for change must make every effort to include all the elements of a community in a truly collaborative effort. This includes recognition of cultural and linguistically diverse groups, class differences, and minority group status. Archer, Kelly, and Bisch (1984:24) were quite succinct about the professional's role here:

> Collaboration can only take place among people who participate. In deciding on the community's desired future, consultants must be constantly alert for the interests of those who are to be affected by change but who for whatever reason are not participants in the process.

Steps in planning include defining the target population that should be included in the planning. That is, planning should be done by and for the people affected. Planning should consider the roles change agents must play and the model of community organization: How much confrontation will be necessary and how much confrontation are people comfortable with? Planning may also require consideration of stages, steps to be completed before additional steps can be taken.

Finally, planning must include planning the evaluation activities. Evaluation represents the feedback loop that provides information on the progress and direction of change-related activities. This means that planning must provide for valid and reliable indicators that the program is on course and is not creating unintended negative consequences. This stage of planning should also provide for agreements for ongoing involvement of the planning group. As plans move forward, it is necessary to evaluate progress and continue to guide the process based on the feedback.

Sengstock (1987) reported on her model of a community intervention to design and implement a service plan for abused wives. Sengstock's work exemplifies the combination of all three of Rothman's models. The project started in 1980 at a time when there was little public knowledge or awareness of the problem and very few services for abused wives in the community. One of Sengstock's tasks was to introduce the problem into appropriate public arenas and get the problem on the public agenda. Sengstock described three broad, sociologically based strategies that resulted in successful outcomes:

1. Provision of information about social structure and its consequences, enabling individuals and groups to use knowledge of social structure to develop more effective plans for group action.

2. Use of sociological principles and data to make people aware of aspects of the social situation of which they were unaware.
3. Involvement of the individuals/group members in the planning process to maximize the likelihood that they will have an investment in the outcome.

Analysis of the social structure of the community directed attention toward those segments that could help achieve the goal. Sociological analysis was also used to determine what task forces were needed. It also helped to identify key individuals who played important roles in various public arenas and included them in planning and implementation committees. These individuals had to have sufficient interest to get involved in the problem, be active in agencies, or have contacts that could influence the initiation of services for abused women. In many instances their public image required that they cooperate and through participation they became invested in the project. Sociological knowledge was also applied as guides to problem definition and goal selection. It was found that people lacked information about the abuse of women and a variety of methods were used to present information on spouse abuse and about service needs and providers. This often meant the dissemination and interpretation of research results in a way that was meaningful to the people who needed this information.

The goal of the project involved changing the way community agencies acted. This necessarily meant including key members of these agencies. Research shows that individuals will be more committed and change is more likely to occur if these individuals are included in the planning and implementation of change. Much of the actual work took place in committees and task forces. Members' commitment and their personal involvement in problem solving as well as their willingness to be guided by social science findings were enhanced by the application of social psychological principles of group process. The sociological practitioner can play a role by facilitating group process and teaching members about groups and group processes. Sengstock's report demonstrated the application of sociological theory, research, and methods in community organization.

Summary

The mesolevel refers to those social structures that mediate between people and the larger social, political, and economic forces within society. We make our living, receive health care, education, and a host of other community services, practice our religion, take political action, and often seek social contact as participants in mesolevel social structures. Sociological practice at this level involves addressing problems within these structures as social problems rather than as problems with individuals.

Social problems arise as products of social structures, their cultures, and the dynamic interaction processes within them. Individual members may be affected as they attempt to cope with and adapt to the situations. However, problems are seen as located in the social arrangements. Problem solving involves sociological

practitioners working as partners with members of client systems to bring about planned social change. The sociological practitioner can make a variety of skills available to the client system. Research skills assist members of the client system in understanding the nature and scope of the problem and in understanding the social system as well as monitoring the effects of change-related strategies. Group facilitation skills are useful in helping a working group with its task. Finally, perhaps the most important contribution sociological practitioners can make is providing information on the operation of social systems. The sociological practitioner provides members of the client system access to the knowledge base of sociology, as sociologists and members of client systems work together for social change.

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5
Problem Solving at the Macrolevel

Introduction

We began, in Chapter 1, by calling your attention to the results of analyses by the Fordham researchers and others of the social health of the United States. In particular, the researchers at the Fordham Institute for Innovation in Social Policy constructed *The Index of Social Health* as a " . . . composite measure . . . designed to profile the social well-being . . ." of the people of the United States as well as citizens of each state (Miringoff, Miringoff, & Opdycke, 2003, p. 21). The *Index* has been published annually since 1987. Table 5.1 lists the social indicators that are included to create the composite score.

Movement along the sociological spectrum, from the microlevel to the macrolevel represents increasing complexity of social systems, broader time frame, and increasing complexity of the social problems that need attention. The indicators listed in Table 5.1 represent a reasonably comprehensive list of macrosocial problems facing the society in the United States at this time. We label them *macro* because they go beyond any given locality or community or organization. They are societal in scope and have a history of some extended duration. And, their effects are felt at the levels of individuals, families, communities, organizations, etc., throughout the society. Problems at the macrolevel are often many-layered and are often connected.

As they exist today, these macrosocial problems—rising inequality, domestic violence, poverty and child poverty, lack of access to health care, homelessness, violent crime, environmental degradation—have a developmental history that covers a relatively long time span. They have not simply appeared; nor have they emerged from a sequence of random events. Choices were available, decisions were made, options were selected. Social institutions have been involved; government and political systems at all levels, economic interests, and other special interests have influenced the public discourse and the direction of policy. The present problematic conditions have emerged from and represent the consequences of accepted ideologies, values, customs, and practices. These have influenced national policy decisions, which, in turn, have resulted in legislation either passed or rejected. These problems arise and are maintained by existing social arrangements and affect a significant proportion of societal members.

TABLE 5.1. Social indicators included in the *Index of Social Health*.

Stage of Life				
Children	Youth	Adults	Aging	All Ages
• Infant mortality • Child abuse • Child poverty	• Teen suicide • Drug abuse • School dropout	• Unemployment • Average income • Health care coverage	• Poverty rate • Health care costs	• Homicide rate • Alcohol related deaths • Food stamp coverage • Affordable housing • Income inequality

Source: Miringoff, et al., (2003; p. 22)

Domestic Violence: A Macrosocial Problem

Violence and the fear of violence (Glassner, 1999) is a significant problem in the United States and a global health problem (Dahlberg & Krug, 2002). It affects people in all stages of life, from infancy to the elderly. In 2003, 17,732 people died as a result of homicide (National Center for Injury Prevention and Control, 2006). Estimates range from 960,000 incidents of violence against a current or former spouse, boyfriend or girlfriend per year to three million women who are physically abused by their husband or boyfriend at some point in their lives. In 2000, 1,247 women were killed by an intimate partner; 440 men were killed by an intimate partner. Approximately one-in-five female high school students reported being physically and/or sexually abused by a dating partner. A national survey of 6,000 families in the U.S. showed that 50% of the men who assaulted their wives also frequently abused their children. Three out of four (76%) women who reported that they had been raped and/or physically assaulted since age 18 said that a current or former husband, partner, or boyfriend had committed the assault (Family Violence Prevention Fund, 2006).

The American Psychological Association reported in 2006, that every year an estimated 2.1 million older persons in the U.S. are victims of physical, psychological, or other forms of abuse and neglect. For every case reported, it was estimated that five more have not been reported.

Data on child abuse and neglect are controversial. Most abused and neglected children never come to public attention or the attention of authorities. From 1976, when the first national figures for child maltreatment were generated, to 1990, reports of maltreatment have grown from 416,033 per year to 1.7 million per year. This increase has been labeled an epidemic (Commission on Behavioral and Social Sciences and Education, 1993).

Because violence has multiple causal factors, it needs to be approached on several levels. The ecological model can be useful and serve a dual purpose. Each

level in the model includes various risk and protective factors and each level can be a point for intervention. Violence at the individual, family, community, organizational, social, institutional, and societal levels involves a number of issues for assessment and intervention planning. Each of the following serve as points for further sociological research as well as issues for assessment in specific instances.

- Identifying individual and family risk factors that influence how individuals become victims or perpetrators of violence and how risk factors can be modified.
- Identifying positive supportive relationships and healthy connections with organizations and social institutions outside the family that reinforce positive coping and problem solving skills.
- Identifying accessible community and organizational resources that can assist dysfunctional individuals and families such as counseling, anger management, parenting and job skills training and other resources for coping.
- Identifying sources of inequality and injustice in communities and social institutions that may prompt violent reacting and reduce the likelihood that persons at risk for violence will get help and support.
- Identifying economic sources of violence at all levels.
- Identifying media and other sources of public information that sensationalize violence and create a climate in which violence is encouraged, fear promoted.

Advocacy groups have addressed this problem. Lobbying and community education are two possible components of an advocacy strategy. They have been used effectively by advocates to increase state protection of victims of domestic violence and state efforts to hold batterers accountable. Lobbying can be an effective way to get laws passed or amended to protect family members from abuse and see that abusers are stopped. Community education is a way to start to change public awareness and perceptions of domestic violence. A public message about violence prevention is an effective way to start change.

Health Care: A Macrosocial Problem

The issue of health care provides another example of a macrolevel social problem. In the U.S., consumers are concerned about rising costs of health care and providing care for their families. Some people have coverage through their place of employment but many remain without coverage. Existing programs such as Medicaid, Medicare, and recent legislation concerning medication for the elderly help some that qualify, but, still, many are left out. Consumer advocates and social critics point to the signifcant proportion of the population that is uninsured or underinsured. Employers express concern about the costs of covering employees and the effect it has on the price of their goods and services in the competitive world economy. Attitudes toward the welfare state and the demonized idea of “socialized medicine” play on public fears and ideologies and exert an influence. Class divisions also influence the debate as the more affluent, who are also

generally healthier, are able to have their needs met, while the less affluent, especially minorities, who also have less political influence, have increasing need for assistance.

Two recent Commonwealth Fund reports analyzed cross-national surveys of adults' health care experiences in Australia, Canada, Germany, New Zealand, Britain, and the United States (The Commonwealth Fund, 2006). Despite spending more than twice as much, per capita, on health care compared to the other countries, the U.S. health care system ranked lower than the others in patients' perspectives on the safety, efficiency, equity, and patient-centeredness of the health care system. The U.S. scored well on the effectiveness of care, especially preventive care. However, the United States also stood out for having wide and pervasive health care disparities and inequities based on income.

An earlier study (The Commonwealth Fund, 2004) found that U.S. patients with lower incomes were more likely to have negative experiences of care compared to their counterparts in other Western countries. The U.S. had significant disparities on 21 of 30 indicators of primary care access, coordination of care, and physician-patient relationships. Low-income patients in the U.S. were last or tied for last on half of the 30 indicators. The report revealed a health care and health divide with negative consequences for the health and productivity of the workforce as well as for lower income families. Uninsured adults in the U.S. are particularly at risk for barriers to access, low quality, and less efficient care.

In 2005, 46.6 million people (15.9%) in the U.S. were without health insurance coverage of any type, up from 45.3 million (15.6%) in 2004. In 2005, 8.3 million children were without health insurance coverage, up from 7.9 million in 2004. About one-in-five (19%) of children in families below the poverty threshhold had no coverage at all. Minority persons were more likely to be without coverage compared to non-Hispanic whites. In 2005, 19.6% of Blacks, 29.9% of Native Americans, and 32.7% of Hispanics had no health insurance (DeNavas-Walt, Proctor, & Lee, 2006).

In a recent editorial, Kressin (2005) pointed to cardiovascular disease in the United States noting that there is as much as a one-third difference in life expectancy between blacks and whites. Blacks have a greater burden of cardiovascular disease and face greater challenges obtaining access to health care, have lower rates of insurance coverage, less access to regular primary care physicians, and more frequent use of emergency rooms for care. Then, once in the health care system, blacks often receive poorer quality of care than do whites. When whole categories of societal members are affected by a problem, we should look to social arrangements for the cause. Kressin emphasized that there are a number of corrective measures that can be instituted. An array of steps was mentioned including pharmacotherapies, prevention programs and educational and awareness raising programs as well as health policy changes and health care quality improvement.

A conference on the disadvantaged in U.S. health care (Brown, 1991) defined the disadvantaged by demographic groups (the elderly, children), by illness (AIDS, mental illness, etc.) and in terms of market and governmental failure

(the homeless, the hungry, the medically uninsured). Other groups who lacked access to specialized health care markets included the disabled, the retarded, the chronically ill, the poor, and immigrants. These specialized groups are identified because, in the U.S., as a society, we do not share the view that the health of all is essential or that services to maintain or restore health should be provided, equitably, for all. As such we do not have a plan to provide such services universally, and there is a health policy for each of these special groups with each group, at various times, proclaiming a crisis.

The lack of an equitable distribution of health services to all segments of the U.S. population is a sociological problem, yet debates about the ways to reform the current "system" of delivering health and social services focus first on economics and how power will be distributed among providers of care. More rhetoric is heard about the kind of health care system we do not want than on the kind of system that we do want, or at least what its essential structure and components should be. Cost is only one of the several issues in the health care reform debate. Race is an issue. Class politics is also involved. And the tension between individual and collective values and between self-interest and shared interests are present (Brown, 1991). There is a societal reluctance to address the issue of shared risk and a refusal to share resources equitably.

Dutton and Levine (1989) stated that there are a host of factors embedded in inequities. The inequities are the result of the cumulative effects of multiple hardships that are disproportionate and synergistic. Piecemeal strategies for improving health among low income groups may be less effective that expected. They pointed out that poor health is interwoven with the position of the poor in the social structure and larger cultural system. The environment of the poor undermines their sense of control and coherence. Intervention needs to change some key circumstances that impinge, disproportionately, on lower income groups. Garber (1989) noted that non-medical interventions can be powerful tools for improving health and interventions applied early in life can have effects long after they are started. Examples include laws governing tobacco sales and use, dietary education, and various forms of prevention programming.

Interventions to reduce or minimize disparities in the delivery of health services in the United States are complex (Kawachi & Kennedy, 2002), and political (Navarro, 2004). Wilkinson (1999) pointed out that, in societies where great income inequality exists, people are cut off from other sources of social status resulting in a culture of inequality. A culture of inequity is a lifestyle resulting from the accumulated effects of disproportionate and inadequate resources for daily living. The challenge for sociological practice is to work with policy makers to adapt and implement health care outcomes of quality, access, efficiency, and equity.

The social problem of health care has been with us for some time. It has been addressed by presidents and political figures of both major parties dating back at least to the 1930s and the New Deal of President Franklin Roosevelt. It illustrates the complexity of social problem solving. At the cultural level, values and ideologies are involved. At the societal level, many constituencies are involved that

include significant status and power differences at work as well as competing views on what should be done and, indeed, whether anything should be done at all. Powerful economic interests – insurance companies, pharmaceutical companies, Health Maintenance Organizations (HMOs), hospital corporations, etc.—are involved. Political parties have taken positions and persuade voters. The U.S. Congress and state legislatures struggle to balance budgetary issues and tax policies with public need and pressure for solutions. Interest groups like the American Association of Retired Persons (AARP) and the American Medical Association (AMA) have taken positions. Physicians and other health care providers have lined up on various sides of the issue. As we have also noted, macrosocial problems are networked. The issue of health care intersects with issues of economic policy and with problems of poverty and inequality as well as issues of race/ethnicity, civil rights, justice for minorities, and class divisions.

Perspectives on Social Change at the Macrolevel

Problem solving at the macrosocial level requires work on policy. Though the terms are often used synonymously, it is useful, here, to clarify the distinction between *policies* and *programs.* Policies are statements of values about desirable goals. Programs, on the other hand, are organized activities to be performed by designated role occupants that are designed to actually achieve the policy objectives.

Most modern industrialized nations have accepted the view that the society has a responsibility for the health of all societal members. They have some form of universal health care program for the members of these societies. However, the United States does not. No universal program exists because universal coverage is not the present policy of the U.S. Policy and legislation are the result of decisions and the design of society. To the extent that the present status of the health care issue is seen as a social problem, it exists because of policy decisions. As Eitzen and Baca Zinn noted, policy is about the design of society. Eitzen and Baca Zinn (2004) have pointed out:

> The politicoeconomic system of a society, from which social problems emanate, does not simply evolve from random events and aimless choices. The powerful in societies craft policies to accomplish certain ends . . . . (p. 563)

The taxation policies which favor the wealthy and very wealthy promote increasing inequality and its consequences including differentials in health, life expectancy, and access to health care. Environmental policies and associated legislation which ignore scientific evidence and international agreements and which favor the profit making of polluting companies accelerate global warming and further environmental degradation. The Welfare Reform legislation of 1996 and other related policy decisions including rejection of proposals to expand health care coverage, to provide child care and assistance to low income families, have drastically undercut the so-called social safety net for poor, working class, and middle class families and children.

At the risk of being redundant we must emphasize: *Policy decisions matter.* Federal policies and legislation of the late 1940s and 1950s created " . . . transportation and lending policies that intensified the rate of suburbanization and therefore reduced demand for housing in urban markets" (Shlay & Whitman, 2004:4). The Federal policy decisions affected local neighborhoods causing disinvestment in certain urban neighborhoods as these policies favored affluent whites who were enabled to purchase homes in the suburban areas. As these families left for the suburbs, poor and minorities persons moved into these neighborhoods. Cities' tax bases eroded which restricted the ability of the cities to provide and maintain services in these communities, which accelerated disinvestment. Crime and violence escalated as housing, streets, schools, and other aspects of the built environment deteriorated. Working persons with families became less and less willing to purchase homes in these neighborhoods. Soon businesses and jobs left these urban neighborhoods and urban blight grew as did urban sprawl as suburban areas grew also.

This brief review of urban history illustrates how the structure and functioning of cities and neighborhoods were affected by actions, decisions, policies and their consequences that occurred beyond the local level. Federal policy decisions affected the nature of neighborhoods, which affected cities' ability to maintain the integrity of the neighborhoods, which affected the various neighborhood institutions which, in turn, affected residents and their well being.

As we consider social change to address macrosocial problems, it is important to be reminded that:

(1) Social problems arise from and are maintained by existing social arrangements;
(2) Social arrangements are not immutable; they are created by people and can be changed;
(3) Social problems are social; they require a collective solution.

To work for social change and problem solving, we must first recognize that change must come from the bottom. Existing policies have been established by elites. It is rare that elites spontaneously or voluntarily give up power or change course in favor of the general welfare. Frank (2004) reminded his readers that:

> Social Security, the FDA, and all the rest of it didn't spring out of the ground fully formed in response to the obvious excesses of a laissez-faire system; they were the result of decades of movement building, of bloody fights between strikers and state militias, of agitating, educating, and thankless organizing. (p. 246)

We do not agree with Frank in his negative characterization of organizing as "thankless." Organizing is central to the work of bringing about changes in policies and social change. Collectively, the people have power but they often need help to recognize this. Change will occur when large sectors of the electorate obtain and exert political power and demand change in a way that political leaders must respond. Or, change can come by replacing the existing political leadership with more responsive leadership. The dramatic changes in congressional

leadership that occurred in the elections of 1994 and 2006 are demonstrations of the influence the electorate can have on policies and policy makers.

Politics is a pervasive influence, direct and indirect, in any situation involving macrosociology. No matter how hard sociological practitioners and social change agents might try to avoid politics, it is inescapable. Funding and politics are usually linked to both the causes and solutions to macrolevel problems. People commonly criticize "the system" as the culprit for many of the social problems. But the system is made up of many players with an interest in protecting their positions, funds, or their degree of control. To address macrosocial problems, to work for social change at the macrosocial level is to enter into the public discourse and to influence the policy debate. That is, to address macrosocial problems is to act politically. It is not a step to be taken lightly. The way is difficult, sometimes dangerous and costly. Often powerful forces are arrayed against change. Change agents may work hard but there is no guarantee of success. But, if nothing is done the likelihood of positive change is reduced to zero.

Problem solving and social change at this level requires political mobilization, a collective enterprise, a collective solution to a shared concern. It is group behavior directed at bringing about social change. It is activity that goes beyond a single organization or neighborhood or community or a single event. The task is to create and mobilize a vocal constituency favoring change that will create social and political pressure for a new policy direction. Social change of this kind requires organization and the work of organizers. This requires leadership and organizing the organizers who will go out to the localities, to each precinct if necessary, and carry the message that change is necessary and that, together, the people have the power to create change. This is community organization writ large. Social change at the macrolevel thus requires something like a social movement.

Social movements are any broad alliances of people who are connected through their shared interest in affecting social change, or blocking social change. Collective action is often based in organizational structure. Often, a critical step for social movements is the development of a relatively formal organization. By "relatively formal organization" we mean one that has a structure of officers, committees, a publication, an address and a web site. These social movement organizations serve as *challenge structures* or *conflict structures*. The purpose is to create an organization to confront existing structures. They serve as a focal point for people to rally around and a resource for local organizations and for maintaining the momentum and ongoing mobilization. Such an organization can help train and organize the organizers as well as workers to keep the issue before the public and the policy makers. The organization can alert and mobilize people for various activities such as meetings, rallies, letter writing campaigns or email campaigns that make people's feelings known to office holders. The larger goal is to create an active and vocal constituency for the desired change.

Examples from history include the Abolitionist Organizations such as the Pennsylvania Abolition Society, and organizations such as the Women's Christian Temperance Union (WCTU) that was instrumental in influencing the onset of Prohibition. Organizations such as the NAACP, The Southern Christian

Leadership Conference, and the Congress of Racial Equality (CORE) were instrumental in the Civil Rights Movement. Other social movements have produced significant changes in the United States including the reporting of hate crimes, men's and women's movements, the environmental movement, and animal rights movement to mention a few. The social circumstances and purposes vary in the making of a social movement, the longevity and sustainability of movements vary and the degree of success also varies. Nevertheless, social movements continue to be effective as interventions for social change at the macrolevel. Mothers Against Drunk Driving (MADD) has played a major role in sensitizing people about alcohol use and driving and has influenced courts and legislatures to aid in keeping habitual DWI and DUI offenders off the road.

Mothers Against Drunk Driving (MADD) is an example of a successful social movement. It was organized in 1980. The impetus was the tragic death of a 13 year old girl who was killed by a drunk driver who had a record as a repeat offender of drunken driving. The rapid development and growth of the organization, fueled by her mother's outrage at the lenient laws and weak judicial response to the crime of drunk driving, developed into a national crusade. With more than two million members and supporters in 2000, MADD has broadened its mission to the prevention of underage drinking by instituting youth programs. MADD is established in all 50 states. By participating in the legislative process, MADD has helped influence passage of more stringent laws against drunk driving and underage drinking. Observers representing MADD often attend traffic court sessions as well, to see whether judges are being too lenient on repeat offenders.

Freudenberg (2005) summarized public health advocacy efforts to change corporate practices that harm the public's health. Tobacco control activists have won new legislation to restrict advertising, limit cigarette and other tobacco use in public places, raise taxes on tobacco products, and have the tobacco industry contribute large sums of money to pay for tobacco related illnesses and support efforts to reduce smoking, especially among the youth. Consumer and environmental activists have targeted the automobile industry for its production and advertising of unsafe and polluting SUVs (Sport Utility Vehicles). Health, food, and nutrition groups have challenged the food industry – including the fast-food purveyors—for contributions to poor nutrition, obesity and diabetes. Antiviolence, public safety, and health organizations have opposed the production practices and marketing of the gun industry. MADD and other groups have criticized the alcohol industry for its youth-oriented advertising. And health professionals, senior citizens, and health-care reformers have taken on the pharmaceutical industry for making windfall profits based on research funded by the public, for covering up harmful side effects of their products, and for disease mongering, creating or exaggerating new diagnoses to promote sales of products (Freudenberg, 2005).

As Freudenberg pointed out, these social change efforts have involved a number of key stakeholder groups including national organizations, coalitions, health professionals and researchers, public health agencies, legal groups, local organizations, media organizations, elected officials and business groups. The actions

taken have included getting information, influencing legislative action, electoral activities, litigation, education campaigns, and campaigns to mobilize people. The outcomes, so far, have covered a range of achievements including a law to ban the purchase, sale, transfer, or possession of handguns by civilians, environmental regulations, and aggressive tobacco control programs.

As these few brief examples illustrate, organizing eventually works. The task involves mobilizing citizens and citizen concern and uniting people to act. But, it also means bringing concerned citizens together with stakeholders and policy makers, balancing demands with what is feasible and doable, and constructing change, collectively.

To address macrosocial problems, to work for social change, you must enter the public arena and join the policy debate if the issue is currently on the public agenda. If the issue is not on the public agenda, you must get your issue placed on the agenda. Obviously, the task is somewhat simpler if your issue is presently a matter of public discourse. In this case, individual change agents (and their clients) would be well advised to make common cause, where possible, with existing actors, groups, and organizations such as political parties, labor organizations, or specific interest groups presently at work. Such organizations have a structure, resources, recognized spokespersons, possible political alliances, communication and interpersonal networks, and personnel that can be useful in initiating and coordinating change-oriented activities. External resources are especially important for movements involving poor people. Local political clubs usually have regular meetings, extensive informal and formal interpersonal networks and social events as well as regular political activity. If allegiance with a political party is appropriate, these local clubs can be a resource and note that they are partially mobilized already.

Starting a movement for change is more difficult. Change begins when a significant proportion of societal members are affected by some condition or policy and become disenchanted enough to feel that change is necessary. But discontent is not enough to promote political mobilization. Persons must become aware that they are not alone, that a significant number of others feel as they do. In addition, there must be a sense that change is possible and that there are structures within society where complaints can be registered, demands for change be heard, and there exists viable alternatives to present policies. The latter is especially important: there must exist a realistic and workable plan that clearly addresses the problem.

Organization and organizers are helpful at this point. A useful step is to identify persons who are ready to work for change at the local level. This is the step of organizing the organizers. Their task may include heightening people's awareness of the existence of a problem and to help them coalesce as a public acting for change. At the local level, organizers can work through local institutions and organizations and pre-existing communication networks. These are important resources for the initiation and spread of ideas and the development of a sense that there is a shared problem and a shared desire for change. As people begin to realize that others share their concerns and desire for change, they are more likely to interact and reinforce each other and spread the word. They are likely to

become a constituency for change. They are more likely to develop strategies and tactics for expanding the constituency and engaging in political action.

Communication and public education is a vital activity in working for social change. As Alinsky (1971, xix) noted, silence is an assent to the present system. The problem must be brought to public attention in a way that people can understand. The public arenas model (Hilgartner & Bosk, 1988) reminds us that social problems are defined and brought to public attention in the arenas of public discourse. But public attention is a scarce resource as various issues and their proponents compete for public attention. Thus, the process of communication must be continuous. Those interested in change must keep their issue before the electorate. There are many channels of communication available and should be used. Today, it is possible to keep in touch with the electorate through blogs and e-mail networks.

Media attention confers status on an issue. The popular conception is that the press and broadcast outlets only cover what is important, so if it is covered, it is important. What gets covered gets placed on the agenda for public discourse. The arenas of public discourse, what Oliver and Myers (1999) referred to as " . . . the abstract space in which citizens discuss and debate public issues," includes the mass media that "link this space to the larger public" who may not be present at public events designed to influence opinions and mobilize people. But the media are more likely to cover the more dramatic events, those that are larger, that involve conflict, and those that happen in central locations (Oliver & Myers, 1999).

Communication must be ongoing. Those interested in change must keep the issue before the electorate. Keeping in touch with constituents and mobilizing people through blogs and e-mail networks also helps keep the pressure on. Frequent mass media coverage helps including things like op-ed pieces and appearances on interview broadcasts as well as making news whenever possible. Public access TV is still another source of potential communication for activists.

Communication is effective when people understand what is communicated. And, people understand things in terms of their experience, in terms of their frame of reference. To reach, inform, and mobilize the electorate, advocates of change must know and understand the frame of reference of the target audience (Alinsky, 1971: 81).

Change is ultimately brought about by human beings who initiate and sustain discourses that challenge the existing structure. First, it is important to get such a discourse going. Moreover, to emphasize the need for change, the discourse has to frame the problem, clearly, honestly, and accurately, as existing because of the present policies, leadership, legislation, etc.

Language is the key to framing. Political groups create a language that reflects their values and use their language, " . . . to move the public discourse in . . . [their] direction." (Rockridge Institute, 2006)

> For example, the market is currently framed metaphorically as a force of nature, as something not to be 'tinkered with' or 'regulated.' But in reality, the market is a social institution with rules and regulating mechanisms that have been put in place by human beings. But this reality is hidden by the force-of-nature framing. (Rockridge Institute, 2006)

The present growing use by political leaders of the phrase "Islamic fascists" can be seen as an attempt to frame U.S. involvement in Iraq as connected to the World War II era and the evil of Nazism. Lakoff & Ferguson, (2006) noted how phrases like "tax burden" and "tax relief" created the sense of taxes as an affliction (rather than a citizen's contribution to and responsibility to the U.S. society that is responsible for their success and lifestyle). This framing has been used to support taxation policies responsible for budgetary deficits, the cutting of social programs, and increasing inequality. As Lakoff pointed out, the words used create as certain worldview. Thus, he suggested, " . . . a basic principle of framing, for when you are arguing against the other side: Do not use their language. Their language picks out a frame – and it won't be the frame you want."

Summary

Macro problems and steps for problem solving tend to be better known because they affect more people and are newsworthy. Macrolevel social problems are also likely to involve more than a single change agent because of their scope and complexity. Macrolevel problems are also networked. That is, they are intertwined with other problems. Therefore, it is important to identify and establish ties with the social networks and support systems that are related to the problem being studied.

Social action, social change and work on introducing or changing policies to address macrolevel social problems is beyond the scope of a single individual, even one sociologist. Practicing sociologists can become involved as part of an interdisciplinary team if working as consultants with a client system. In this case, the client system might be an interest or advocacy group, a political organization, or some other collectivity that realizes a need for professional assistance to deal with a social problem at this level. Alternatively, as sociologists, we are also citizens. We may bring our professional expertise to bear on issues that concern us.

The task is to create a unified and vocal constituency that will work for the desired change. People must become aware that a significant problem exists and come to realize that collective action can and will bring positive change. Sociologists can provide useful scientific research to provide information on the scope of the problem and the likely course of events if conditions are left unattended. However, no matter how credible the research, unless it enters the public sphere, it will not help to raise awareness and concern. Those who do such research should consider contributing op-ed pieces and other forms of information through popular media. In addition needs assessments and various forms of survey research can help determine public awareness and concern that can assist planners in developing ways of focusing public attention for additional mobilization.

In the assessment process, sociologists can provide a critical analysis of the problem: why does the present situation exist and how did it get that way. What social arrangements maintain the problem? What realistic options and alternatives exist? What are the barriers and potential drawbacks? What are the likely

outcomes of various alternatives? The assessment should also provide direction for mobilizing people and the best ways to reach them. Additional assessment should identify resources, allies, and potential sources of support for mobilization and social action as well as sources of resistance.

As the process starts, it is important that the early risers, those people that are among the first to express concern and a willingness to work for change must be given encouragement and reinforcement. They must be kept informed and the early risers can be organized to become community organizers who go out to the localities. Practicing sociologists with knowledge and experience at community organizing can help train, organize, and encourage them.

Program planning should include the development of alternative and workable policy and the process of working to get it adopted. Policy makers and program planners also have a need for information. Sociologists with expertise in a problem area, such as health care, can be a resource for policy makers and program planners by providing theoretical and empirical information to guide planning.

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6
Multilevel, Multi-Factor Problem Solving

Introduction

In previous chapters we described methods for approaching the solution and prevention of social problems at the micro, meso, and macro levels. In reality, the causes and solutions to most social problems are multidimensional. They involve more than one level. Examples of current social problems that involve micro, meso, and macro levels are: homelessness, poverty, racism, violence, environmental pollution, gun control, the death penalty, nuclear waste, weapons of mass destruction, health care, alcohol and drug abuse, and immigration. Many social problems are interrelated, they have common causes and solutions. As Lindblom and Cohen (1979) said, "when society tries to solve one problem it often creates others; when society tries to solve one problem, it often solves others" (p. 50). Warner (2000) pointed out that extrapolating from the effective control of one behavioral public health problem to others should proceed with caution. For example, gun control and the reduction of alcohol abuse have borrowed intervention lessons directly from tobacco control. The three behaviors share the similarity that they are multidimensional problems with life- limiting consequences, but they also differ in the immediacy of these consequences.

Social change broadens the scope and complexity of social problems. For example, eating disorders such as anorexia and bulimia which became common in the United States in the 1970s and 1980s have recently become common in Japan (Church, 1991). Researchers have shown that specific historical and cultural factors helped to shape the experience of eating disorders as Japan became more Westernized. These factors include gender development and gender role expectations of females, beauty ideals, and the importance of shape and weight (Pike & Borovoy, 2005). Social change adds a layer of complexity to problem assessment and the approaches to problem solving. Church (1991) pointed out, "the important thing for the sociological practitioner at the microlevel is to remember that uniquely sociological insights about individual behavior and emotions relate to an understanding of the macro and meso level structures within which they ultimately occur" (p. 138). Similarly, it might be added that sociological work with organizations, large groups or social institutions, should be aware of meso and macro effects on individuals.

The focus of our discussion of problem solving has been on the assessment of *a* problem, the client's presenting problem. But problems do not stand alone; problems beget other problems. Practicing sociologists will be engaged in multi-factor and multilevel problem solving with any client. Progress in resolving the client's presenting problem will necessitate the client's willingness to examine other problems that affect the solution to the presenting problem. The objective of this chapter is to discuss how to approach solving social problems considering their multi-factor, multilevel nature.

Before we begin we should point out that, over the past several decades, there has been an emerging population of individuals with chronic mental health and criminal justice problems. These clients are often labeled "multi-system, multi-problem" clients because they are difficult to understand and to treat. Members of this population have several common features including early alcohol and/or drug use; progression of the use of stronger and more addicting substances; the absence of supporting, nurturing environments, and the presence of abuse. In this chapter our concern is not with specific categories of clients. Rather, we focus instead on examining the best strategies for addressing social problems that cross various levels of social organization and have multiple causes.

The Development of a Social Problem

Lindblom and Cohen (1979) said, "we do not discover a problem 'out there,' we make a choice about how we want to formulate a problem. For example, war is often taken to be a problem, yet nations use war as a solution to problems" (p. 50). Fuller and Myers (1941) believed that every social problem consisted of an objective condition and a subjective definition. The objective condition is necessary but not sufficient to the definition of a social problem. Social problems are also what people consider to be a threat to their values.

Several social psychologists have developed a conceptual model consisting of four criteria that need to be met for a situation to be considered a social problem (Ovcharchyn-Devitt et al., 1981). These are: 1) negative effect, 2) a large number of people affected, 3) chronicity and intractability, and 4) social consensus. All four factors should be considered in defining a social problem. Once a social problem has been identified guidelines can be used to assist the interventionist in choosing an intervention strategy or strategies that will have the greatest probability of success. The model specifies five salient aspects of any social problem that need to be identified:

1. The process of the problem, or the dynamics of the problem behavior.
2. The characteristics of the groups or persons affected by the problem.
3. The impact of the problem.
4. Environmental and interpersonal factors that co-vary with the problem, such that its indirect consequences and associated phenomena will be taken into account.
5. Knowledge of any substantiated causes of the problem, obtained through review of past attempts at intervention, and relevant research.

Each of these five categories of information is necessary for the consideration of any social problem. In addition, the unique configuration of information obtained throughout this process suggests the level or levels, i.e. micro, meso, macro, to intervene to solve the problem. Once an intervention strategy is implemented, the next step is to reassess the problem to decide if the condition still meets the criteria of a social problem. Should the four criteria show little change from their initial levels, the information gathering process would need to be repeated and another intervention strategy implemented, or the previous strategy reformulated (Ovcharchyn-Devitt et al., 1981).

Multilevel, Multi-Factor Problem Solving

Cohen (2002) pointed out the stubborn persistence of illusions about the relationship between mental illness, crime, unemployment, and poverty when only a microlevel approach is used. Mental illness may appear to be the dominant factor at the point of entry into homelessness, unemployment, or prison. However, when questions are asked about distal causes such as, what is it about persons with mental illness that make them more likely to become homeless?, there is evidence that factors such as poverty, unavailability of low-cost housing, and the inaccessibility of services more strongly explain why a mentally ill person shows up at a shelter than does his or her psychosis (p. 899).

Cohen emphasized that a multilevel approach of the effects of the relationship between poverty and mental illness on outcomes such as homelessness, unemployment or criminality can be understood by at least three different models, which are not mutually exclusive. The first model suggests that the relationship between poverty and mental illness is *additive*, that is, mental illness may have an independent effect on homelessness, and poverty further increases the likelihood of homelessness. A second model proposes that the relationship between poverty and mental illness may be *interactive*; the likelihood of homelessness increases as the level of poverty or mental illness increases, and conversely, if the level of either poverty or mental illness is low, the risk of homelessness is much less. A third model suggests that the relationship between poverty and mental illness is *dialectical* so that they are mutually transforming. Therefore, poverty alters mental illness so that the mentally ill person who becomes poor is more vulnerable to homelessness, or conversely, a poor person who becomes mentally ill is more vulnerable to homelessness.

Syme (2004) wrote about the difficulties interventionists in public health have experienced in getting people to change their behavior. He noted that the prevalence of smoking in California has decreased from 43 percent to less than 20 percent in recent years. This outstrips the successes public health has had in their smoking cessation programs. Syme explained that the most effective interventions were policy changes initiated by the public, such as raising the price of cigarettes, limiting access to cigarette machines, enforced strict limitations on magazine and billboard advertising, and prohibiting smoking in public places. Syme stated, “most of the successes we have achieved in behavior change have

come about because they have been the subject of a multi-pronged, multilevel, multidisciplinary approach. These approaches involved not only information, but also laws and regulations, mass media campaigns, workplace rules, and better environmental engineering and design. We developed interventions that involved a variety of partnerships and went far beyond the narrow confines of the health field" (p. 4). Syme concluded his overview of lessons learned over a long career as an epidemiologist by recommending the use of better proactive strategies rather than waiting to fix problems after they occur.

Ellis (1998) discussed how recent increases in adolescent substance abuse, an escalating delinquency rate, and increasing numbers of youth suffering the consequences of sexual promiscuity suggest that many prevention activities may be insufficiently comprehensive. He noted current prevention programming often fails to address specific antecedents. For example, a youth identified to be at-risk for school dropout might be given tutoring and social skills training, yet his association with negative peer groups might be ignored. If the youth is not provided with resources to address negative peer influence, the dropout prevention activities may be useless. Thus, the intervention for this youth did not address multiple causal factors.

Current prevention programming also often neglects factors that protect against negative antecedents. A youth who lives in a chaotic family environment and is exposed to negative peer influences might have extended family members who are positive models and mentor the youth. Protective factors can minimize or eliminate the effects of negative factors.

Current preventive programming often fails to consider unique cultural or other individual factors that impact youth at different stages of development and in different ways. For example, there is evidence that youth of different ethnicities react differently to risk factors (Vega, Zimmerman, Gil, Warheit, & Apospori, 1993), and that differences may exist between genders (Ellis, 1997; Flannery et al., 1993). Therefore, youths from different ethnicities may require different interventions even though they may experience the same social situation or condition.

These examples illustrate the need for multi-factor interventions that have micro, and macro components, that is, interventions must address all known risk factors, not just those related to a specific problem behavior.

Hawkins, Catalano, and Miller (1992) noted that risks and protective factors occur in multiple systems of youth's environment. Certain risk factors might be primarily concerned with the individual, others might be connected with the family, still other factors might be related to the neighborhood or community, and to the school. Since risk factors are interactive, and levels interact, it is important to consider how each level is unique and how they interact collectively.

Planning interventions at the microlevel cannot be optimally effective without consideration of factors at the macrolevel. Ellis (1998) stressed that like multi-factors, multilevel and multi-system intervention is both micro and macro. It is micro in that it evaluates community resources in light of individual needs. It is macro in that programs must be created or modified to meet the diverse and collective needs of individuals and groups.

An Ecological Approach to Multilevel, MultiFactor Problem Solving

One of the recommendations of the Institute of Medicine's Committee on Capitalizing on Social Science and Behavioral Research to Improve the Public's Health (Smedley & Syme, 2000), stated "rather than focusing interventions on a single or limited number of health determinants, interventions on social and behavioral factors should link multiple levels of influence (i.e. individual, interpersonal, institutional, community and policy levels)."

An increasingly popular approach to the study of, and intervention in, multilevel, multi-factor, and multi-system social problems is the use of the ecological model, which we discussed and illustrated in Chapter 2. The ecological approach solves one of the major shortcomings in interventions in social problems, that is, generalizing from the microlevel to the macro and vice versa. David Holtgrave of Johns Hopkins University (2006) has said "reaching the individual is necessary, but not sufficient . . . . if we want to change individual behavior, a very powerful way to do that is to work on the social norms." Tolan, Gorman-Smith, and Henry (2006) also expressed the limitations of staying focused on the microlevel.

In a recent review of family violence these authors pointed out that, although there has been considerable study of the patterns, risk factors, and interventions in the various forms of family violence, great controversy still exists because there is an overlap in the patterns, causes, and interventions. These authors said that there is an awareness of the need for greater integration of theory and research across types of family violence through an ecological perspective. This perspective means emphasizing a multi-factor, multilevel understanding of violence that can: 1) help explain a high prevalence as well as a low prevalence; 2) examine population patterns but also account for individual differences among any population; and 3) uncover patterns that suggest both predisposing and precipitating factors (Cicchetti, Toth, & Maughan, 2000; Daro, Edleson, & Pinderhughes, 2004).

There are dozens of competing theories of the causes of child, intimate partner, and elder maltreatment that could be incorporated into a broad ecological framework. The prevailing sociological paradigm within the field of family violence derives from the work of Bronfenbrenner (1979) who argued that human development and behavior should be understood within a nested set of systems. The micro system consisted of the relationships between developing individuals and their immediate settings. The meso system consisted of relationships among the settings in which the developing individual is involved. The macro system consisted of cultural factors, including views about the role of children and their caretakers in society.

Building on Bronfenbrenner's model, researchers have identified causes of child maltreatment, spousal abuse, and elder abuse at different ecological levels. Inherent in the ecological perspective is the need to understand the genetic endowments of individuals, and the micro systems in which they grew up as well as their current micro system and other system levels. The ecological perspective

includes consideration of social, behavioral, cognitive, and affectual factors at micro, meso, and macrolevels (Hines & Malley-Morrison, 2005).

Issues in Applying the Ecological Approach

Appropriate Use of Theory

Turner (2001) emphasized that most sociologists are interested in how sociology can help others, how it can make a difference, and how it can make the world better. Therefore, he suggested that scientific interventions should be theory-driven activities as opposed to assumptions based on professional experience.

Identifying Relevant Factors at each Level

Ellis (1998) emphasized if a practitioner applies the ecological approach to a problem, both risk factors and protective factors need to be identified that bear on the problem at all levels (micro, meso, and macro). Both risk and protective factors are important in prevention. Prevention is based on the premises that: 1) risk factors exist and can be identified; 2) the effects of risk factors can be minimized or eliminated by directly addressing them; and 3) the effects of risk factors can be minimized or eliminated by enhancing certain protective factors (Dryfoos, 1990; Hawkins et al., 1992). A partial list of risk and protective factors at the micro, meso, and macro levels using family violence as an example is shown in Table 6.1.

Ellis (1998) noted that comprehensive prevention programs should be multifactor, multi-system, and multilevel. Interventions for social problems often address only a few risk factors at one level and often neglect protective factors. Furthermore, interventions often address only one of the social systems in which risk factors occur, such as the family, school, or neighborhood.

There are several other observations about risk factors that are relevant to preventive interventions (Hawkins et al., 1992). Risk factors appear to remain stable over time despite societal changes; risk factors occur in multiple social systems including family, school, workplace, peer groups and the community; risk factors appear to affect youth differently at different stages of their development; the greater the number of risk factors present, the greater the risk; and some factors do not appear to generate risk when they exist alone, but may have a powerful effect in combination with other risk factors (Hawkins et al., 1992).

These observations are important insights into why some preventive interventions fail. Ellis (1998) pointed out: 1) since risk factors occur in multiple environments it is important that all systems be addressed; 2) interventions must be adapted to address risk factors at different stages of human development; 3) the interactive and additive nature of risk factors emphasizes the importance of addressing *all* known risk and protective factors; 4) the different impacts of risk and protective factors on various ethnic groups, and between genders, emphasizes the importance of culturally relevant interventions; and 5) the stability of risk and protective factors indicates that failures in prevention are not necessarily due to

TABLE 6.1. A partial list of risk and protective factors relevant to using an ecological approach to interventions in family violence.

	Risk factors	Protective factors
Microlevel (Individual; Family)	• witness to and experience violence • access to guns • depression • aggressive behaviors • drug/alcohol abuse • poor social skills • poor anger control • low self-esteem • low family support • mental illness • unemployment • unplanned, unwanted pregnancy	• strong extended family • good social skills • resilience (hardiness) • cognitive, social, and emotional competence
Mesolevel (Community; School; Peers)	• poor school performance • social isolation • problem peers/neighborhood • neglect • stalking • poverty	• commitment to school • peers, schools, communities that emphasize positive social norms • recognition and support for participating in positive activities • supportive relationships with adults • opportunities to become involved in positive activities
Macrolevel (State; National)	• male dominance and physical abuse as an acceptable norm for problem solving • permissive societal attitudes and practices regarding violence/anger/discipline • minor consequences for violent behavior • media portrayal of violence	• hotline • counseling • prevention programs • partnerships between law and public health agencies • self-help groups

changes in the nature of risk factors, but that the intervention may have been inappropriately or insufficiently applied.

Identifying What is Doable

Client's often identify "a piece of their life situation" as their presenting problem. During the problem assessment phase, this "piece" must be put into context. Some aspects of the client's situation may not be subject to change or intervention either because of the client's reluctance to consider contingent factors, or because the total situation is chronic, or too complex to modify within a reasonable time. Therefore, a practitioner must focus on what is doable within the contractual relationship with the client carefully specifying expected outcomes. Indeed, some

presenting problems especially those at the macrolevel, require the expertise of several disciplines and the coordinated efforts of an interdisciplinary team, for example, in an organizational merger, or in a statewide effort to change the law regarding the death penalty.

It is important that the boundaries of client's problems be established or "framed" so that specific objectives with achievable outcomes can be established within reasonable time frames. Identifying what is doable does not mean that problems can be effectively solved piecemeal. Problems should always be looked at in their total context. Problem solving, however, can be phased so that interventions are not overwhelming. To "frame the boundaries" of a problem means to establish some parameters so that the problem can be put in a manageable framework for interventions to be meaningful. The broader the definition of the problem, the greater the complexity in selecting and implementing interventions and assessing their effects, none of which may work because the problem was too ambiguous or comprehensive.

Number, Types and Phasing of Interventions

An ecological approach to problem intervention usually means that there will be multiple interventions of different types appropriate to different levels of social organization, and these may need to be phased and possibly repeated to reach sustainable intervention goals.

Smoking cessation programs provide a good example for the need for multiple intervention strategies. A number of approaches at the policy, legislative, and regulatory levels have been attempted to effect widespread reduction in, or prevention of beginning to use tobacco. Various efforts at the community, state, and national levels have been credited with reducing the prevalence of smoking over time. These include: reducing minors' access to tobacco products, disseminating effective school-based prevention curricula together with media strategies, raising the cost of tobacco products, using tobacco excise taxes to fund community-level interventions including mass media, providing proven quitting strategies through health care organizations, and adopting smoke-fee laws and policies (National Cancer Institute www.cancer.gov/cancertopics/pdq/prevention/control-of-tobacco-use/health professional). Multiple interventions have been used with some success in preventing and stopping tobacco use among large groups of people.

The Community Intervention Trial for Smoking Cessation (COMMIT) was a National Cancer Institute large-scale study to assess a combination of community-based interventions designed to help smokers quit. COMMIT involved 11 matched pairs of communities in North America, which were randomly assigned to a community with an active intervention or to a control community with no intervention. The four-year intervention included messages sent through existing media channels, major community organizations, and social institutions capable of influencing smoking behavior in large groups of people. The combined interventions significantly increased smoking cessation rates among adults who smoked less than 25 cigarettes per day, but not among heavier smokers.

Single and multiple factor interventions have only been minimally effective in reaching low-income and racial and ethnic groups who have consistently high rates of tobacco use and higher mortality from smoking-related diseases than the United States general population. Studies have provided information on a variety of interventions for different racial and ethnic groups, but there is no consistent evidence that targeted cessation programs result in higher quit rates in these groups than do generic interventions of comparable frequency and intensity (U.S. Department of Health and Human Services, 2000b). Culturally appropriate strategies and matching individuals with interventions that are meaningful to them may increase success in these populations.

What Worked and What Didn't Work

Evaluating the impact of multilevel interventions is complex and frequently challenging especially if it is believed that intervention components may be synergistic. For example, a longitudinal multiple time series of three matched intervention communities was carried out over a period of four years to determine the effect of community-based environmental interventions in reducing the rate of high-risk drinking and alcohol-related motor vehicle injuries and assaults (Holder et al., 2000). Outcomes were assessed by general population telephone surveys conducted monthly of randomly selected individuals in the intervention and comparison sites, traffic data on motor vehicle crashes, and emergency department surveys in one intervention-comparison community and one additional intervention site. The objectives of the intervention were to mobilize the community, encourage responsible beverage service, reduce underage drinking by limiting access to alcohol, increase local enforcement of drinking and driving laws, and limit access to alcohol by using zoning. Results indicated that a coordinated, comprehensive, community-based intervention can reduce high-risk alcohol consumption and alcohol-related injuries resulting from motor vehicle crashes and assaults. It was not possible to determine which program components were most effective. However, the cumulative effect changed social norms and had a positive effect on the problem.

Doll, Bartenfeld, and Binder (2003) noted that, in the case of multilevel interventions, it is not uncommon to have multiple outcomes, including some that are unintended or unexpected. For example, in a review of youth violence studies, it was found that, while delivering interventions in adolescent peer groups can have benefits, they also can increase smoking and delinquent behaviors (Dishion, McCord, & Poulin, 1999). Williams, Reinfurt and Wells (1996) found that the enhanced enforcement of seat-belt laws resulted in increased arrests for other crimes. In interventions one must not ignore unintended outcomes as they can provide insights into why programs worked or didn't work (Doll et al., 2002).

Reinforcement and Follow-up of Interventions

There is evidence that reinforcing-based interventions, especially interventions targeted to life style changes, are more effective than single contact interventions. The Air Bag and Seat Belt Safety Campaign of the National Highway Traffic Safety

Administration (1998–2005) is an example of how reinforcement and follow-up are critical in changing habits. Law enforcement agencies from multiple jurisdictions designate several concentrated periods throughout the year to conduct intensive enforcement of seat belt and passenger safety laws in states and regions. This effort has an enforcement component, a media component, and a public education component.

In the enforcement component seat belt checkpoints stop vehicles at fixed locations to determine seat belt and child safety seat use. Saturation Patrols focus on concentrated geographic areas which are high traffic areas. Fixed Patrols, with officers at fixed locations such as schools or intersections near schools, or shopping centers, check for seat belt use.

In the media component, coverage is given to make enforcement efforts highly visible. The possibility of receiving a ticket has been shown to be as effective as receiving an actual ticket in enhancing seat belt compliance. Media reporters cover enforcement activities for news stories. And media and law enforcement and other community organizations create partnerships to promote enforcement efforts.

The public education component focuses on teens and young adult drivers. This involves a broad national coalition of organizations. The Campaign has developed partnerships with over 50 corporations and national organizations including the AAA, insurance companies, physicians' professional societies, motor vehicle manufacturers, trucking companies, and pharmaceutical companies to name a few. Local organizations support community enforcement activities such as child/family vehicle check-up clinics.

Since the Air Bag and Seat Belt Safety Campaign began:

- Child fatalities have decreased by more than 20 percent;
- Child restraint use for infants under one has risen from 85 percent to 99 percent, and restraint use among toddlers, ages 1–4, has increased from 60 to 94 percent;
- Adult seat belt use rose from 62 to 79 percent, the highest use rate ever, with more than 50 million Americans using seat belts.

There are several points that are helpful in reinforcing behavior change. First, it is advantageous to know what reinforces change; some reinforcement techniques may be considered noxious or used so frequently that they are ignored as information overload. Second, risk factors and protective factors can change; it is helpful to know what the changes are in order to adjust reinforcement strategies. Third, reinforcement should be tied to the terms of the client's initial agreement of accountability. In this way reinforcement strategies are understood as extensions of the initial client-practitioner contract. Fourth, situations and problems can change in priority following an intervention. Hence, it is possible that a client decides not to follow through on his/her initial agreement and declines attempts to assist them in sustaining the effects of an intervention. While reinforcement might be a high priority with the practitioner, it may become less so for the client. Fifth, reinforcement can be a part of follow-up; reinforcement should be designed to meet the client's needs, follow-up should also meet the practitioner's need for feedback about what worked and didn't work.

Follow-up is especially important when multiple interventions are used. The practitioner has a need to know which parts of the interventions have been helpful and why, and what the client suggested, in retrospect, may have been more helpful to them. In this sense follow-up itself is a kind of intervention.

Social Problems are Never Completely Solved

Some social problems are solvable; some are partially or temporarily solved, still others seem to linger and often grow. As has been said, solutions to problems often create new problems. This is because humans are enveloped in change. Interventions that are chosen to be appropriate to the lifecycle needs and social situations of clients or social systems at one point in time may become less appropriate as clients change. The lifecycle model discussed in Chapter 2 is helpful in putting a client's problems in a developmental perspective, especially in identifying themes that reoccur throughout their lives and discovering the dynamics of how circumstances, events, and transitions become problematic for them.

An Ecological Challenge: Reducing Health Disparities in the U.S.-Mexico Border Region

Reducing health disparities among different segments of the American population is one of the national objectives for the United States issued by the Surgeon General in his *Healthy People 2010* report (U.S. Department of Health and Human Services, 2000a). Disparities have been defined in terms of differences in health status, risk factors for disease and injury, access to and use of health care services, and differences in the quality of health care received. Disparities are inequalities that prevent some members of our society from getting their needs met. Most research, and many conferences, have focused on identifying methods to eliminate health disparities among high risk groups such as racial and ethnic minorities, low socioeconomic families, the uninsured, the homeless, or the elderly, where the cumulative effects of multiple hardships are disproportionate and synergistic. Since many of these groups share similar enabling characteristics, a multi-factor, multilevel approach to reducing disparities is needed. Interventions could perhaps be more effective if they were designed to address risk factors that are shared among several at-risk groups. For example, homeless individuals share the risk factors of being poor, uninsured, alcohol and drug abusers, and having multiple chronic health problems.

Health disparities are prevalent in the six Mexican states and four U.S. states that form the 2,125 mile border between the United States and Mexico leading to The Healthy Border Program established by the U.S.-Mexico Border Health Commission in 2003. The United States and Mexican border communities have collaborated on joint health improvement activities for several decades. Some of these activities have been short-term because of the lack of continued funding or

changes in leadership. Some projects have been limited to sister communities, while others have been state-wide or border-wide programs. Still other projects have focused on a single disease while others have been concerned with regional problems (U.S.-Mexico Border Health Commission, 2003). Despite these efforts, border health disparities do not appear to be decreasing. This may be because there is a need to change the infrastructure of health care services and their delivery, not just focus on programmatic activities. Therefore, the U.S.-Mexico border region is in need of an ecological approach to resolving disparities that span the social structures of two cultures (Bruhn, 1997).

An ecological approach to solving and preventing border health problems has several advantages: 1) it can focus on several problems which share the same risk factors; 2) it provides a holistic and dynamic framework for planning interventions; 3) it shifts the emphasis for quick-fix solutions to long-term ones; 4) it factors in the continuing effects of social change; and 5) it involves all levels of a living system.

Border health problems are simultaneously local and international, therefore, interventions in one country or at one level will not bring about lasting solutions. The lack of interest, inconsistent funding, changes in political leaders, and clashing values have all been blamed for piecemeal and episodic attention to border health. Immigration has further complicated already existing inequities in care and services. Yet, the United States and Mexico could begin by agreeing upon a superordinate goal – to minimize self- and societal-induced health risks that reduce the quality of life and survivability. This goal cannot be mandated by government, rather it needs the support and buy-in of citizens and leaders in the border region.

Warner (2004) has proposed integrating the U.S. and Mexican health systems along the border, especially as the two countries integrate economically and demographically. One aspect of Warner's proposal focuses on cross-border certification and training of health professionals as one way of dealing with work shortages in the U.S. health care system. Binational policies could also prove cost effective for Medicare as increasing numbers of beneficiaries retire in Mexico. Warner suggested that, if Medicare reimbursed providers in Mexico, access could be increased, and expenses reduced.

Warner's proposal of integration may be workable with respect to specific aspects of health care such as the training of providers or policies regarding payment for services. It has been found that population groups with the poorest health benefit the most from improved access to health care (Starfield, 1985). Indeed, the frequency of occurrence of conditions that can be prevented declines in response to the provision of medical care. Yet, inequalities in the availability of medical care or utilization cannot explain a large portion of the link between health and socioeconomic status. Poor health is interwoven with the position of the poor in the social structures and larger cultural systems of the U.S. and Mexico (Dutton & Levine, 1989). The question that needs addressing is what created the disparities and what are the constraints that inhibit changing them. This is the ecological challenge for the U.S.-Mexico border.

Summary

Most social problems are complex, multi-dimensional, and interdisciplinary. Social change is a continuous force that changes the nature of social problems and broadens their scope. As a society we are involved in an on-going process of problem solution and problem creation. Solutions to problems tend to spin off new problems. The task for sociological practitioners is how effectively to meet clients' needs by addressing their presenting problem while at the same time seeing their problem in a broader context.

Since the causes and effects of problems are interwoven, solutions may require clients to make significant changes in their values and lifestyles. Therefore, interventions that improve clients' problem-solving skills and help them to make less risky proactive choices are considered effective for certain clients.

Even though interventionists are aware of the complexity of social problems they have too frequently focused their interventions on a single or limited number of factors at a specific level of social organization. Many interventionists from the social and behavioral sciences and from public health have expressed their views that such a narrow focus has led to only small and usually temporary changes. An increasingly popular approach to intervene in multi-factor, multilevel, and multi-system social problems is the use of the ecological model.

We discussed several issues relevant to the effective use of the ecological model including the appropriate use of theory; identifying risk factors at each level of social organization; identifying what is doable; determining the number, types, and phasing of interventions; identifying what worked and didn't work; employing reinforcement and follow-up following interventions; and recognizing that few social problems are ever completely or permanently solved. The ecological approach was used to better understand possible interventions in U.S.-Mexico health disparities across national borders.

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7
Evaluation Research

Introduction

Throughout our discussions of intervention, we have consistently maintained the importance of program evaluation as an integral part of the intervention process. The purpose of this chapter is to focus specific attention on the evaluation stage. It should be noted that program evaluation is almost a discipline in itself and many sociologists and other social scientists are often employed as program evaluators. Their task is to evaluate ongoing programs for clients who call upon them for this specific activity. This chapter is not intended to be a treatise on program evaluation from that perspective. Here, our concern will focus on a sub-set of the broader world of program evaluation: program evaluation as a part, a stage in an overall intervention. That is, we direct your attention to the situation where the sociological practitioner works with a specific client/client system to design and implement a specific problem-solving intervention.

Inclusion of this chapter on evaluation is based on our experience that the evaluation step is often added after the fact or ignored completely. There are a variety of reasons for this. Evaluation is often a difficult task and the more complex the social system that is the target for change, the more difficult the evaluation becomes. In some cases, the nature of the change process is such that effects take time to accumulate. Clients may be eager to get a program underway but may not be willing to commit the resources necessary for a long- or even mid-range evaluation. It may also be difficult to sustain the interest and energy of those involved to conduct a proper evaluation. It may also be difficult to maintain a commitment to evaluation because those who planned and implemented the intervention program are content with what they see happening; they claim to "know" the intervention is "working" (though they are seldom able to articulate *how* they know). Finally, evaluation may get short shrift because intervention program activities, which may compete for time, energy and other resources, are given first priority.

We insist that to ignore evaluation or to relegate it to an afterthought status is to do an incomplete job. Our view of evaluation, as we discuss it here, is guided by the following:

1. Program evaluation should be an integral part of program planning.
2. Program planning, as derived from the assessment step, should include clear, operationally defined, and measurable objectives.
3. Program planning should include the evaluation steps as part of the implementation process.
4. The timetable for program evaluation should begin when program implementation begins.
5. Program evaluation should provide a steady flow of feedback on the course of the implementation of an intervention program.

Definition, Purposes, and Essential Steps

The more common sense definition of evaluation is that it is a social process of making judgments of worth or value. Evaluation research refers to those procedures for collecting and analyzing data which increase the possibility for demonstrating rather than merely asserting that some activity has worth (Suchman, 1967). In this chapter we focus on using social research methods for the purposes of conducting evaluation studies.

Whenever one asks such questions as "How good is the program?" "What effects are we having?" "Is the program working as expected?" and uses such instruments as rating sheets, appraisal forms, evaluation guides, or research designs which involve comparing activities before or after, or in the presence or absence of a particular action, it can be said that an evaluation is being conducted. Klineberg (1955) defined evaluation as a process that enables administrators to describe the effects of a program and to make progressive judgments in order to reach the goals more effectively. The purposes for doing an evaluation can be explained by how evaluation studies can be used:

1. To discover whether and how well objectives are being fulfilled.
2. To determine the reasons for specific successes and failures.
3. To uncover the principles underlying a successful program.
4. To direct the course of activities with techniques for increasing effectiveness.
5. To lay the basis for further research such as replicating aspects of successful programs in other settings.

The goal of evaluation research goes beyond simply determining the success or failure of a program or intervention. The aim is also to know why the program succeeded or failed and to apply this information to the present and to future programs. It is also important to share this information with other workers in the field through publication and informal contact with colleagues. Thus evaluation involves more than judging, it includes understanding and refining the process of program development. To aid evaluation as well as program development,

Herzog (1959) offered a useful set of questions to guide program development and evaluation:

1. What kind of change is desired?
2. By what means is change to be created?
3. What is the evidence that the changes observed are due to the means employed?
4. What is the meaning of the changes found?
5. Were there unexpected consequences?

Why Evaluate?

In the broader world of evaluation, there have been times when evaluators have been viewed with suspicion. As Weiss (1972) suggested, in one of the early, classic works on evaluation, evaluation has been used for political purposes as part of power struggles in agencies or organizations. The goal of such evaluations was seen as supporting or attacking various cliques and interest groups that were for or opposed to certain policies or courses of action. In other contexts, evaluators were seen as tools for justifying decisions already taken. Where these have been staffing decisions, staff members have felt their positions threatened by evaluators' findings. Sometimes, conducting an evaluation has been seen as a way of delaying or postponing decisions. And sometimes, evaluations have been used as public relations moves. We follow Weiss's view that these are inappropriate uses of evaluation.

The definition of a problem and the development of an intervention indicate a resolve to take some action to ameliorate the problem. The purpose of intervention is to achieve some predetermined outcome. The policies and programs are hypothesized to achieve the desired outcome. Intervention can be viewed systemically. Assessment, problem definition, and objectives can be viewed as input. The planning and implementation of policies and programs can be viewed as "process." The activities and consequences are the output. Evaluation is critical to this cybernetic model as the feedback loop. Evaluation is a feedback mechanism for "course correction." As we have consistently stressed (See Chapter 3, Figure 3.5) evaluation may prompt a need for further planning, and/or additional assessment with concomitant adjustment of program activities. Figure 7.1 suggests the role of evaluation.

Shadish, Cook, and Leviton (1991:21) described the role of evaluation in similar terms:

> Evaluation is just one part of a complex, interdependent, non-linear set of problem-solving activities. Such evaluations have always been with us and always will be, for problems will always occur, solutions will always need to be generated, tests of their efficacy will need to be done, and the test results will have to be stored if they are to help.

In this passage, Shadish et al. point to another important role of evaluation: storing the results which contributes to institutional memory. Both the client system under study and the sociological practitioners stand to gain from the information generated in the course of evaluation. All can learn what works and what does not

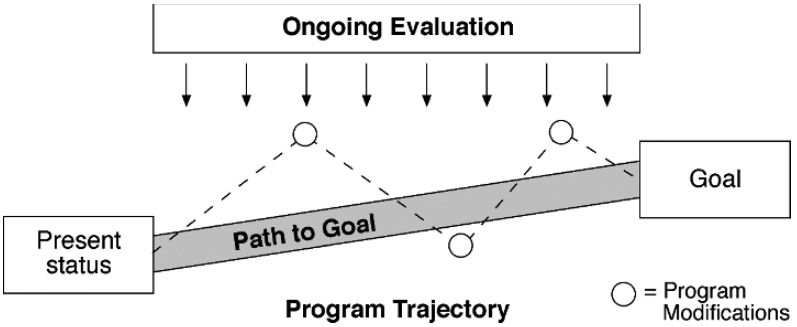

FIGURE 7.1. Scheme of Role of Evaluation

work. What is learned from evaluation can be used to improve developing programs. The client system benefits as it learns more about its problem-solving options. Evaluation also provides accountability for the use of resources. Practitioners gain in experience that may transfer to other situations and may also contribute to theory development generally. Evaluation also provides information for program diffusion. Rossi and Freeman (1993) wrote:

> In order to be able to reproduce the essential features of an intervention in places other than where it originated, it is necessary to be able to describe the program in operational detail. Critical points in implementation need to be identified, solutions to managerial problems outlined, qualifications of successful program personnel documented, and so on.

Finally, evaluation is important to intervention to uncover unintended consequences. Efforts for change in a social system or any of its parts may produce other undesirable effects. One such effect may be resistance to change. For example, a system of merit pay increases was introduced into a school system intended to recognize "superior" teachers and efforts in the classroom. The program was intended to improve the quality of teaching. However, the result was divisiveness and reduced morale within the system. Staff members who did not receive the recognition and merit increment responded with anger and hostility. They asserted that they worked as hard as those teachers who received the increment. Eventually, the "merit" increments were given to all staff thus defeating the original idea. Planners had not anticipated the broader results of their plan.

Some attention to possible "side effects" during the assessment and planning stages will be helpful. In the above example, the merit pay idea was an idea of the school administration. They might have achieved a better outcome for the merit pay plan had they involved teachers and perhaps the county teachers association (union). More generally, they might have achieved a better outcome for the improvement of classroom instruction with better planning and broader participation to include teachers, parents, community members, and perhaps even students. Generally then, sociological practitioners and others involved in change need to be alert for *other* consequences as they plan and implement intervention programs and investigate them as part of evaluation.

It is not possible, however, to anticipate all, and perhaps not even most, other consequences of intervention. Weiss (1972:33) pointed out that intervention might address one aspect of a complex problem. "Even if they achieve good results in their area, the more important effect may be to throw the original system out of kilter." The systemic nature of all social systems compels us to look for unintended consequences.

In summary, the answer to the question, "Why evaluate?" has several parts:

1. To keep a planned intervention on course toward the goal by revealing a need for additional assessment data, or additional planning, and/or changes in the program;
2. To learn about the intervention as it develops to be able to improve it;
3. To reveal dysfunctional unintended consequences brought on by the various parts of the intervention;
4. To contribute to the problem-solving efforts of the client system and to the development of the field generally.

What to Evaluate?

Evaluation is a research task that can tap the full range of experts' knowledge of research methods in social science and their ingenuity and creativity as well. Two considerations govern our approach as developed here. First, it is our view that evaluation is an integral part of the intervention process. This means that evaluation is built into the design of the intervention program. The assessment should point the way to a definition of the problem, establish a baseline, and clarify what needs to be changed and how to change it. In addition to planning intervention components, program planning should frame concrete statements of objectives, timetables, and identify stakeholders, decision makers, and other consumers of evaluation results. The evaluation should be designed as the program itself is being designed. Those responsible for the evaluation should be a part of the project team at the outset and evaluation should begin early in the overall process. This is the moral of the story in Application 7.1.

APPLICATION 7.1 Identifying Problems in Program Implementation

Katherine Williams, Ph.D., is a sociological practitioner who works with youth gang and drug prevention programming. She was an outside evaluator of the project described below and began her evaluation on the last day of the project year.

This federally funded youth gang drug program for adolescent females is operated by the public housing authority in a large Eastern city. Six housing sites were selected for this program due to the presence of female gangs. The application for funding describes the program as a multistage intervention program that addressed risk factors and provides interventions on multiple levels.

Staff positions include a Program Coordinator, six youth workers, and three "specialists" who provide services to all six sites. Meeting space is provided for the girls and the youth worker at each site.

The program is to include daily alternative activities such as recreation, sports and field trips for girls organized by the youth worker at each site. In addition, there are two "specialists" who rotate through the sites each week providing the girls in the program with personal growth and development workshops. The "Personal Growth Specialist" provides sessions on self-esteem, physical fitness, personal hygiene and grooming, birth control, and self-confidence. The "Leadership Specialist" focuses on informational sessions and activities that develop leadership skills. The third specialist position is to provide family support services although this position has remained vacant during most of the program.

Interviews with staff and site-visit observations indicate that the program outlined in the formal description was not being implemented in a consistent fashion. Several factors hampered the successful implementation of the planned program including conflicts between program staff and tenant councils, a lack of consistent supervision, and a significant lack of communication and cooperation among the staff.

In order for the program to maintain a consistent presence at a site, the program needs a stable meeting space that the girls can begin to associate with program activities. Often the relationships between the Housing Authority and the Tenant Associations were problematic. The relationship between the youth worker and the Tenant Association in her site was critical to the continued existence of the program at the site. One youth worker was banned from the site by the Tenant Association and others had difficulty finding sufficient meeting space to hold program activities. When program activities stop due to lack of meeting space, the girls lose interest and find other activities.

Lack of communication among staff also hampered program implementation. As one worker stated "at meetings people never share ideas and talk about problems so other staff members can offer advice." The lack of communication and cooperation was particularly acute between the specialists and the youth workers at each of the sites. The Personal Growth Specialist indicated that "probably the most frustrating and aggravating thing that I've encountered since my stay, is showing up at a site to conduct a workshop and no one is to be found. Youth workers ignoring my schedule and taking their kids on a field trip – happens frequently. I only visit each site once a week for about two hours. You would think the youth workers could set aside that time for me so I could perform my workshop."

The Leadership Specialist echoed this same frustration. "I didn't perform any workshops this week at the sites because when I showed up to teach, no one was to be found. Youth workers constantly ignore the schedule I submit to them at the beginning of every month."

Identifying problems in program implementation is one very important function of evaluation. Williams' study of the program revealed personnel problems and problems of liaison with important stakeholders. Workers were frustrated, resources wasted, and conflicts existed. These problems affected the ability of the program to reach the target group and to carry out the intervention program. If evaluation had been an early and regular component of the plan, these problems could have been identified and possible solutions found.

Source: Williams, K. L. (1995) Personal communication (HMR).

The second consideration is in line with our general view that the sociological practitioner's role is one of partnership and collaboration with clients. The sociological practitioner's role with regard to evaluation is to negotiate the evaluation procedures at the time that other intervention components are negotiated. It should be part of the contracting with clients. It is also the sociological practitioner's role to contribute expertise and advice on the technical aspects of the design of evaluation materials and procedures and to offer instruction in their use.

In our discussion of mesolevel practice in Chapter 4 we called attention to the views of Whyte (1989) and others on Participatory Action Research. We believe that the process continues into the evaluation stage. Guba and Lincoln (1989:11) called for "*full participative involvement*" of stakeholders and others "as equal partners in every aspect of design, implementation, interpretation, and resulting action of an evaluation . . . ." For Guba and Lincoln this means "*political parity* and *control*" as well as "*conceptual parity*" among professionals and members of the client system (emphasis in original.) The professionals are advisors and team members. They take part in ongoing dialog with members of the client system who are the ones who own the intervention including the evaluation.

Weiss (1972:20) addressed the issue of whether evaluation should be conducted by outside evaluators or "in-house" members of the client system. Outside evaluators may sometimes have more credibility with certain decision makers and may be thought to be somewhat more objective. However, evaluators who are part of the client system and part of the working team may have greater understanding, easier access to information, and be more readily able to apply the information. Weiss was referring to the larger practice of program evaluation. In our model here, which is concerned with evaluation of problem solving intervention and participatory research, we suggest that the evaluation component is part of the project from the start. It is the contribution of sociological practitioners to see that a good evaluation is planned, carried out, and used. If a real participatory model is developed, the members of a client system will support and want the results of evaluation.

The evaluation phase must find out: (1) if the planned intervention steps are occurring as planned and if not, why not; (2) what are the consequences of the intervention, both intended and unintended. The design of the evaluation stage, then, requires the development of data on these issues. The key to good evaluation, as in any research, is conceptualization of the research task. By now it should be

clear that the evaluation is driven by the statements of the objectives. As we address the question, "What to evaluate?" three subordinate questions arise:

1. Are the planned intervention steps occurring as planned?
2. Are the planned intervention steps producing movement toward the objectives?
3. What were the consequences?

These are the questions that underlie the three types of evaluation to be described here: Process Evaluation, Program Monitoring, and Impact Evaluation.

Process Evaluation

Process objectives state what must be accomplished to achieve the changes desired. They should be stated in terms of units of activity by designated role-occupants. Evaluation design should provide for early and frequent assessment of process issues. Obviously, the specifics of data collection will be dependent on the level–micro, meso, or macro–and the nature of the client system–individual, family, organization, community, etc.–as well as the specific purpose of the intervention. Here we will suggest some general points for process evaluation.

When a program plan is developed, it should specify who does what, when and how. It should also produce quantifiable goals and objectives. The purpose of process evaluation is to determine to what extent the planned events occurred as planned. Process evaluation should include the assessment of any materials that might be used in the intervention program, such as questionnaires. Are the materials appropriate to the task? Are they suited to those who will use them? For example, if training is to take place, as a step toward the desired change, evaluation of the curriculum and curriculum materials will help estimate whether training will be effective. Is the curriculum appropriate to the training objectives? Are the content and materials presented at a level and in a language that can be comprehended by the target audience; are they too simple or complex for the level of the target audience? Are those persons who will do the training qualified, familiar with the curriculum, and competent with the materials? This type of evaluation can be used to "fine tune" the materials themselves and their adaptability to those who will use them.

Program planning should clearly state the various process objectives in unambiguous, measurable terms. An example of a process objective might be:

> To conduct 10 two-hour training sessions for 15 workers in the _____ department each Wednesday afternoon from 3:00 to 5:00 PM in _____.

Process evaluation will need to determine if the training occurred as planned. Was each session held? Did the identified workers attend regularly?

It may be necessary to conduct a retraining program for personnel to achieve a successful outcome. Therefore, in guiding the program, it is important to assess whether this step was needed and whether it occurred. More generally, the evaluation should note what events and activities are supposed to occur, in what sequence, and should determine if they occurred as scheduled. If they are directed at an identified

target audience, evaluation should also assess whether that target audience was reached. Additionally, if there are budgetary matters, process evaluation should assess whether or not funds are being used appropriately and if budgetary constraints as well as accounting and documentation requirements are being adhered to.

If the events did not occur as planned, evaluation must also attempt to discover why. Questions for study might include: Did those responsible have the resources and training, knowledge, and skills for carrying out their responsibility? Did they lack motivation? If so, why? If the target audience was not reached, what were the reasons? Was the time schedule appropriate (e.g. working moms may not be able to come to parenting classes scheduled in the morning)? Are there cultural, language, physical, or other barriers such as a need to have transportation or child care?

Attention to possible cultural barriers is important. Often well-meaning programs directed toward ethnic minorities, the poor, or homeless fail to connect with the target audience because sponsorship, materials and activities are not culturally syntonic. Inclusion of members of the target population in the planning process can help in developing culturally appropriate activities and measurements.

The task of process evaluation is made more difficult if the program is to be conducted at more than one site. Not only must evaluation determine issues of delivery but issues of standardization and continuity need to be assessed. These will have to be weighed against needs to adapt to variations in local conditions.

Process evaluation, then, is an important part of conducting any intervention. Steps are planned that are hypothesized to lead to problem-solving. If the objective is to be achieved, the steps must be carried out as planned if they are to have a chance to work. Often programs fail, not because of poor design, but because they were not executed according to the design. Process evaluation is the source of feedback to project managers and the client system on whether or not the problem-solving steps are occurring as planned.

Process evaluation should cover every phase of program delivery. That includes analysis of management strategies, interaction among participants, materials, activities, personnel appraisal, and client acceptance. This assessment is an important aid to program development. Planners need to know, not only whether plans were carried out, they also need to know what is happening so that obstacles and barriers can be quickly identified, addressed, and perhaps eliminated.

Application 7.2 describes a project whose outcomes could have benefited from attention to process evaluation. The moral of the story is the need for process evaluation and the need for early involvement of evaluation.

APPLICATION 7.2 Identifying Problems in Process Evaluation

The program described here was an after-school program for middle school youth who lived in a public housing project near the school. It was intended to target youth who were at high-risk for school failure and becoming dropouts. Teachers and administrators at the school were given certain guidelines and

asked to identify children for referral to the program. Most of the children lived in single-parent homes.

One feature of the program was the requirement that children's parents had to participate for the child to continue in the program. Children taken into the program were given the responsibility for informing their parents and getting them to attend evening sessions, first scheduled every other week and later scheduled once a month. Program staff eventually tried sending notes home with the children, but apparently no staff tried direct contact or outreach to the parents. Children whose parents failed to attend were eventually dropped from the program. The program finished out the year serving primarily children who were not the original target group. All of this was learned as program evaluation began after the program had ended for the first year.

Reference to project documents revealed that one of the process objectives of the project was parental involvement including parents' regular attendance at the scheduled evening sessions. As noted above, these were originally planned as bi-weekly but attendance was so light that this was changed to once a month in an effort to improve attendance.

Earlier involvement of the evaluator and earlier attention to process evaluation may have helped to identify problems related to the lack of parental involvement and have permitted adjustments that would have kept more of the target children in the program and have permitted staff to work with the parents and spared them the disappointment and the feeling that "these parents just don't care enough about these kids."

Moreover, the parents are key stakeholders in this project. It seems that all planning took place without participation with parents, which, itself, was a process problem that detracted from the chances of success for the program.

Recommendations were made for changes in methods for getting parents involved and for having evaluations begin immediately for the following year.

General issues for process evaluation include:

1. Are intervention activities occurring as planned?
2. Are target groups or individuals being reached?
3. How do stakeholders, project personnel, and target persons respond to intervention activities?

With individuals and families, the use of diaries and record keeping can help provide data on compliance with agreed-upon activities. These, of course, are subject to all the flaws of self-report data. Reports may be incomplete or inaccurate for a variety of reasons. It is helpful if clients clearly understand the importance of this task and if they own the intervention. Clients will be more resistant to data collection if they feel that it is something imposed upon them. Where possible, self-report data should be augmented with observation. Where institutions are involved in efforts to change an individual's behaviors, outside sources of data can sometimes be obtained with written permission from clients and

negotiation with these sources. For example, liaisons with school personnel may provide both process data as well as data on behavioral changes of children and adolescents.

The variety of meso- and macrolevel interventions makes generalizations about process evaluation procedures difficult. However, these interventions have in common the fact that they often designate a target group or population. Intervention activities must reach this target group and members must participate in sufficient numbers for change to occur. Thus, concern for process evaluation may include whether or not the target group has access or is being reached, and continues to participate or drops out. Some types of programs may involve outreach activities or recruitment of participants. Process evaluation will need to determine the effectiveness of these efforts.

Rossi and Freeman (1993) discussed evaluation of the coverage of community based interventions involving health or social services delivery. By "coverage" they meant the extent to which a program reached the intended target population, those persons in need of program services. Assessment of coverage includes determination of bias, the extent that certain subgroups of a target population show differential participation. Assessment of coverage also includes determination of the extent to which persons not designated or not in need also obtain services. For example, consider a school-based catch-up program designed for students who are identified as behind in reading skills of three or more grade levels. The objective is generally to improve reading skills. However, if only good readers are enrolled in the program, outcome measures will make the program look good but it will not have reached those in need. On the other hand, if teachers use the program as a dumping ground for behavior problems, regardless of students' reading ability, the program is not serving its intended audience and outcome evaluations will be irrelevant to the original objective.

Coverage issues also involve access. The question for access is, Can members of the target population or group readily participate or are there barriers? Rossi and Freeman (1993) identified *eligibles, utilizers,* and *dropouts*, those who are members of the target population but do not participate, those who do, and those who start but do not continue. Data on the differences among these groups is useful for process evaluation.

Data collection methods include direct observation, records, surveys, interviews, and group meetings. Direct observation, either participant or nonparticipant observation, can be useful in determining how intervention activities are conducted. The observer needs to be trained in what to look for and in how to use the standard forms for recording. A large intervention, however, could make this approach expensive and time consuming. In addition, the presence of the observer may alter the behavior of those being observed. The frequent presence of the observer can reduce the sensitivity of those being observed to some degree. More important, if appropriate relationships are established at the outset, and the participation model is followed with cooperation and participation agreements secured, the threat of the observer's presence can be reduced when those being observed understand that it is the intervention that is being studied. Direct

observation on the intervention program can be a rich source of information on how it works and where the glitches are.

Various forms or records will also help, either those normally kept by an organization or those designed specifically for the purpose of process evaluation. Examples include records of events, number and nature of participants, activities conducted, units of services provided, problems encountered, etc. Care needs to be taken that record keepers are trained to provide accurate and complete records and that the record keeping system is not so cumbersome or time consuming that it competes with or interferes with other activities including the performance of intervention activities.

Surveys of various kinds are another data source for process evaluation. Items and the samples to be surveyed will, of course, depend on the purpose and location of the intervention. Such things as awareness or perceptions of intervention activities and level of participation can be obtained through this method. In small projects, it may be possible to survey all persons affected. In larger projects samples from a target population can be used. For example, a survey may help a program discover differences among eligibles, utilizers, and dropouts, and provide input to improve coverage of the target population.

Interviews and group sessions can help identify problems with other data collection techniques. Participants may include project managers, staff, target groups, members of the working group, etc. These sessions can add details and impressions on the course of program activities.

In sum, process evaluation covers a variety of activities designed to determine if the planned activities are occurring as planned and provide feedback to planners and decision makers on the course of intervention. The best planned interventions will not achieve their desired outcomes if the plan is not carried out with care.

Program Monitoring and Impact Evaluation

The objective of all problem-solving interventions is to bring about specific changes. At the microlevel, with "Tony," who we introduced in Chapter 3, objectives included improvements in his school behavior and academic performance. At the mesolevel, organizational objectives might include such things as increased productivity, reduced conflict, improved communication, or the improved health and safety of workers. Community objectives might include improvements in schools, improvements in infra-structure such as streets, lighting, housing or sanitation, or improvement in health and social services. At the macrolevel, objectives may include the reduction of disparities in healthcare, racial justice, reduction of homelessness, or reduction of abusive behavior. Whatever the level, whatever the problem, the purpose of program monitoring is to see if the hypothesized policies and programs are producing change in the desired direction.

The general purpose of program monitoring is to determine whether an intervention program is achieving the intended effects. A program plan has the functional status of a hypothesis; it is hypothesized that implementation of the policies and/or

programs will achieve a specified objective which is the solution to an identified problem. The objective can be considered the dependent variable while the new policy or program can be considered the independent variable. As implementation gets underway, decision makers have to decide whether to continue to pursue the present course of action or to modify their strategy. Generally, outcomes may include: (1) change is occurring in the desired direction; (2) no change is occurring; (3) undesirable change is occurring. The task is to establish a credible link between intervention activities and observed outcomes. This is akin to the problem of establishing a causal inference in scientific research.

Just to remind readers, there are three criteria that must be met to support a causal inference. The first is *concomitant variation*; it must be shown that variation in the antecedent conditions, the independent variable, is associated with variation in the consequent, the dependent variable. The second is *time order*; it must be shown that the variation in the presumed antecedent occurs prior to that of the presumed consequent. The third criterion is *alternative explanations must be ruled out*; it must be shown that variation in the consequent is attributable only to variation in the antecedent and not to other influences. Of the three requirements, the third is usually the most difficult to meet.

The more complex the social system in which intervention is being conducted, the more difficult it will be to establish a valid causal inference, particularly in establishing the third criterion. Rossi and Freeman (1993) noted in the complex social world there are multiple causal factors operating in addition to an intervention that may affect social systems. In addition, with larger social systems, effects of the introduction of new policies and programs may be small and occur slowly.

To confound the evaluation task a bit more, interventions are often a "work in progress." In scientific experiments no one decides to change the experimental stimulus in the middle of the experiment. Intervention programs are often developmental and decision makers may not be willing or able to await outcomes before changing the intervention.

Impact evaluation is concerned with results, of finding out how well the intervention worked. One basic question for impact evaluation is "Were the objectives met?" In addition, it is also useful to sort out the contribution to results of various components of the intervention. For both theoretical and practical reasons, it may be useful to learn which components of a program are essential, which are merely nice to have, and which are unnecessary or perhaps even counter-productive. As with program monitoring, the task for impact evaluation is to demonstrate a cause-effect relationship between program steps and components and observed outcomes. We recommend to be wary of premature closure. Just because the evaluation shows desired effects, it does not mean that the occurrence of an intended outcome had anything to do with the intervention.

In addition to the course of planned changes, evaluation must assess other effects of the intervention on the client system, on other social systems, and on individual members. Impact assessment also refers to efforts to determine the nature of unintended outcomes of intervention as well as long-term effects. Here again, the research task searches for a credible link between a possible or observed

impact on one hand, and the intervention elements themselves and the planned changes on the other. Weiss (1972:33) recommended brainstorming "... in advance about all the effects, good, bad, and indifferent, that could flow from the program."

Program monitoring and impact evaluation start with the statements of objectives. One of the requirements of the planning stage is the articulation of clear statements of outcome objectives in terms that are observable and measurable. The task is to design research with appropriate indicators that assess whether or not objectives are being met. Below, we will address the design issue, but note that the task of ruling out alternative explanations is the most difficult part of the task.

Problem solving interventions are some set of planned activities designed to bring about behavior change on the part of designated role-occupants, the target group, which in turn, alter a problematic situation. Figure 7.2 presents the situation graphically. As the figure shows, there are nine paths as pure types. The issue is confounded since overlaps can occur. Other behaviors in addition to the target behaviors may change. Other outcomes in addition to the target outcome may also occur.

Program monitoring and impact evaluation are used to determine the extent to the planned implementation led to outcomes and consequences that they were designed for. We recommend that quantitative methods are central to the research task but that evaluators should also include qualitative research methods. The latter add richness of detail and experience to the evaluation. Research designs include observational studies, case studies, single-case designs, quasi-experimental designs, experimental designs, and survey designs. The more powerful designs are those that provide for comparison. Here we will review each briefly.

Naturalistic Observation: Much can be learned about what is happening in a setting by simply observing the setting, becoming familiar with the context, its patterns and rhythms, and being open to discovery. Conversations with various

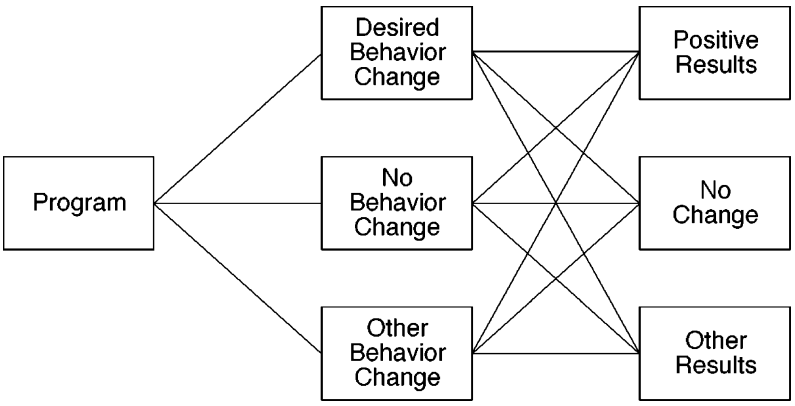

FIGURE 7.2. Paths of Probable Outcomes

key respondents add to an observer's understanding of participants' meanings for events and activities and what they feel is important. The more varied the social location of such key respondents, the broader the picture an observer can get.

In this method, the observer is the data-gathering instrument. Guba and Lincoln (1989:176) asserted that:

> Humans collect information best and most easily through the direct employment of their senses: talking to people, observing their activities, reading their documents, assessing the unobtrusive signs they leave behind, responding to their non-verbal cues, and the like.

Guba and Lincoln also referred to the "tacit (implied) knowledge" that observers can employ; our own experiences, skills, knowledge and training provide the ability to understand and judge the materials of observation. Our tacit knowledge provides the basis for making an informed judgment. Observers drawn from the social system as well as sociologists can contribute useful insights. Preparation of observers through training will always improve their performance.

Naturalistic observation gives richness and context which, when combined with systematic quantitative data enhance an understanding of the effects of interventions. However, the presence of the observer always adds an element that may influence what/who is being observed. This can be softened to a degree by the observer's frequent presence. As the observer becomes a familiar (accepted) part of the background, the effect of the observer's presence may be reduced. The value of the observation can be increased if observation was part of the assessment stage or can begin sufficiently prior to the implementation stage so that the observers have some idea of "baseline" behavior in the setting. It is also helpful if observers have some systematic method of recording observations that usually range from open-ended narrative to structured checklists and rating scales.

The disadvantages, as pointed out by Rossi and Freeman (1993) are that naturalistic observation can be time consuming, is not easily taught to untrained observers, and may produce data that are not easily summarized or analyzed. We do not recommend this as the only approach but one used together with other approaches. However, naturalistic observation is an especially good step in getting to know the setting and the program.

Case Study: Yin (1994) has explained that the case study is one of several ways of doing social science research. Other ways include experiments, surveys, histories, and the analysis of archival information. Each strategy has its advantages and disadvantages, depending upon three conditions: 1) the type of research question; 2) the control an investigator has over actual behavioral events, and, 3) a focus on contemporary phenomena when relevant behaviors cannot be manipulated. In general, case studies are the preferred strategy when "how" or "why" questions are asked, when an investigator has little control over events, and when the focus is on a contemporary phenomenon within a real-life setting. Such "explanatory" case studies can be complemented by two other types, "exploratory" and "descriptive" case studies (Yin, 1994:1).

A case study focuses on a single individual, group, or community. The value of a case study is determined by the extent of the details reported. O'Leary and Wilson

(1987:362) stated that the basic criteria for case studies include a complete and precise description of intervention methods to permit replication, the complete specification of the problems to which the methods were applied, and specification of the characteristics of clients. However, because case studies are uncontrolled, they have limited value in drawing causal inferences from intervention to outcome.

Many researchers disdain case studies because they lack rigor ("soft" research), or because they confuse case study teaching with case study research, or because case studies provide little basis for scientific generalization, or because they take too long to do and yield massive documentations (Yin, 1994). The major steps in deciding the value of a case study should be, first, identifying the research question, second, determining what evidence is most appropriate to answer the question. Data from case studies may come from documents, archival records, interviews, direct observation, participant-observation, and physical artifacts. The third step is analyzing the data, and finally, composing the report to address the needs of a specific audience.

The ability to draw some inferences from a case study can be improved to a degree according to O'Leary and Wilson if: (1) the study includes objective evidence of change instead of anecdotal reports; (2) the study relies on continuous or repeated assessment rather than single pre- and post-evaluation; (3) reasonable projection of the course of the problem if left unattended is made (some problems might disappear or change in nature whether or not an intervention takes place); (4) change is coincidental with specific interventions, the larger the effect the more persuasive.

The lack of control is a limitation. The case study method does not rule out alternative explanations for the observed outcomes. As noted above, some problems are resolved with the passage of time, the maturation of the persons or systems involved, or changes in the social, political, and economic context. In addition, change might be due to the Hawthorne or placebo effect: Just paying attention and/or appearing to do something may induce behavior change; however, the specific intervention program may have had little to do with the changes that occurred.

Single-Case Experiments: Single-case experimental designs help to overcome some of the disadvantages of case studies by introducing some control. In these designs the case acts as its own control. These designs were developed as a feature of behavior therapy and were intended as a way of monitoring the effects of behavioral psychotherapy with individuals. However, they are offered here with the view that they may be applicable for sociological practitioners not only with individuals but with other cases as well.

To be useful, single-case designs require a clear, well defined objective criterion measure. Examples of criterion measures include frequency of problem or preferred behaviors by an individual or group, measures of time, dollars, test scores, number of units of output, etc. The logic of these designs is similar to that of time-series analysis.

The simplest design is characterized as the AB design. After a period of baseline measures (the A stage) of the criterion, the intervention or treatment is introduced

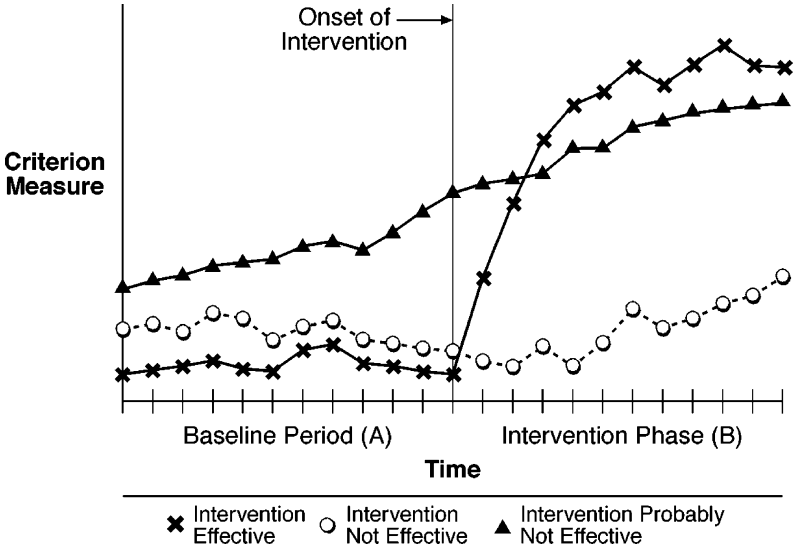

FIGURE 7.3. Example of Simple AB Design

with continued monitoring of the criterion. The intervention is said to be working if the criterion shows measurable change. Figure 7.3 gives an example. The baseline period acts as the control. Line 1 shows the intervention appears to have been effective since the upswing in the curve appears to have been coincident with the onset of the intervention. Line 2 shows no effect of the intervention. Line 3 shows a steady increase in the criterion measure, but that it is likely not to have been attributable to the intervention since the baseline trend merely continued upward.

A modification in this design is the withdrawal or "baseline, ABA" design (Leitenberg, 1973) in which, after a baseline period, the intervention is initiated for a period, withdrawn for a period, then reinstated. If the intervention is inducing change, withdrawal should be accompanied by a return to baseline and should show effects again when reinstated. This design, if it comes out as illustrated in Figure 7.4 provides stronger evidence for making a causal inference about the intervention than does the simple AB design. However, not all interventions are reversible. It may not be possible to use this design, either because of the nature of the intervention or for ethical reasons.

Multiple baseline designs can be used where an intervention has several components to address and several criterion outcomes which can be initiated sequentially. Figure 7.5 illustrates multiple baselines across behaviors (Leitenberg, 1973; O'Leary & Wilson, 1987). For each target behavior, criterion measures are taken. After a baseline interval and taking measures of all three behaviors, the first intervention component is initiated for one of the problems. The others are left unaddressed. They continue as baseline and are addressed sequentially. If no change occurs until each intervention is initiated, there is some basis for a causal inference.

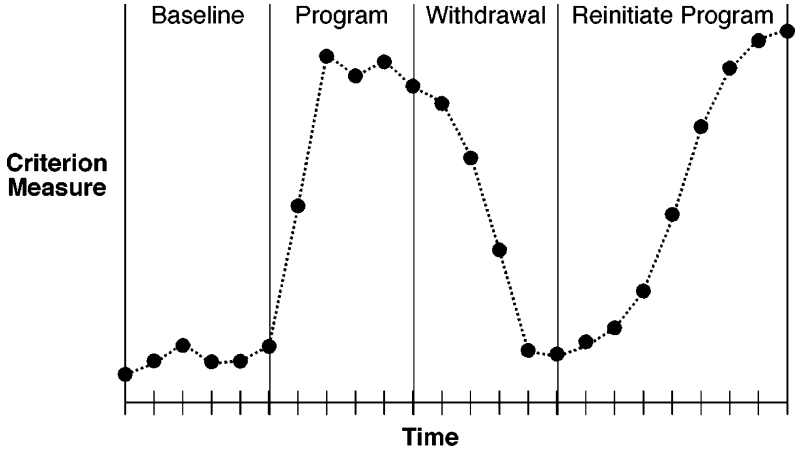

Figure 7.4. Example of "Baseline ABA" Withdrawal Design

We can also have multiple baselines across individuals or cases where intervention is to be initiated at more than one location. In this instance, baseline data are kept on all cases and interventions are initiated sequentially with each individual or unit. There is some basis for causal inference if each case or individual shows a similar response to the initiation of the intervention.

These designs have certain limitations. First, they will not reveal how, or in what way, the uniqueness of the case affected the intervention. This will, of course, affect the generalizeability from one setting to another. Second, findings are fairly unambiguous when there are stable baselines and dramatic, or steady,

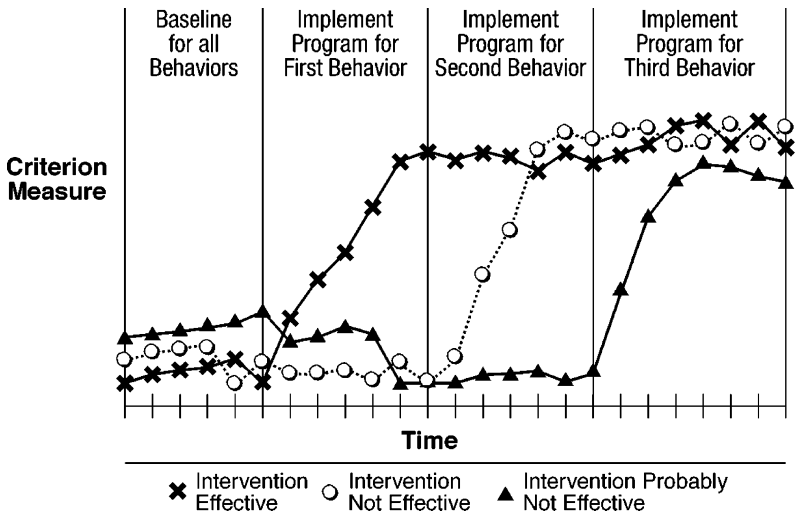

FIGURE 7.5. Example of Multiple Baseline Design

changes following the onset of intervention. When these conditions are not clearly met, interpretation may be more difficult. Finally, these designs do not totally rule out Hawthorne or placebo effects.

Nonetheless, these designs can be useful particularly in program monitoring. They offer some evidence of the effects of the intervention while it is underway. They may be less relevant to the longer term effects of impact evaluation. However, Leitenberg (1973) suggested that long-term follow ups are not precluded. The use of controlled monitoring can be an aid in determining if planned intervention steps affect the outcome variables of interest.

Experimental and Quasi-Experimental Designs: Most of us have been taught that experimental designs are the most powerful designs when attempting to establish a causal inference. These designs require random selection of subjects or at least random assignment of subjects to treatment groups. They also require careful control of presentation of the various levels of the independent variable or treatment, and the presence of one or more control groups that receive no treatment and/or placebo-type treatment. The control groups provide the basis for comparison. Random assignment of subjects to treatment and control groups supports the assumption that groups are similar at the outset and that the only difference between them is the treatment. These procedures are attempts to control the sources of invalidity identified by Campbell and Stanley (1963) – history, maturation, secular trends, selection bias, etc.–which amounts to ruling out other causes.

True experimental designs have a limited applicability to the type of evaluation discussed here. The following hypothetical example comes close: A local health department includes both a mental health and addictions treatment unit. Aware of the frequency that psychiatric disorders and addictions disorders co-occur, the department prepared a dual-diagnosis program. Each new intake is randomly assigned to the new program, a former treatment, or is placed on a waiting list for treatment at a later date. Patients are assessed at intake on some common criterion measure. The purpose of pre-measures provides data to test the assumption of similarity among groups. The various treatments are conducted, patients are re-assessed at some later date, and results compared among the various groups including those placed on the waiting list who acted as a no-treatment control group.

The term *quasi-experimental designs* describes designs that do not meet all the criteria for true experiments. The so-called intact-groups design is an example. In this design, the program or treatment variations are presented to one or more existing groups with one or more groups left as no-treatment comparison groups. It helps if groups can be randomly assigned to treatment conditions. Criterion measures are collected on all treatment and no-treatment groups both prior to and following treatment and comparisons are made. These designs might be reasonably applied to interventions in school systems, for example, where classroom groups are the intact groups. A sufficient number of groups from within a system and random assignment of groups to treatments may provide a reasonable basis for a credible causal inference about an intervention program.

The further one deviates from the experimental model, the weaker the causal inference. For example, the less like the treatment group that the comparison group is, the less comparable the outcome measures and the less credible the inference from the comparison.

Survey Designs: Surveys involve the use of standardized questionnaires administered either as cross-sectional or longitudinal designs. Cross-sectional designs refer to single administrations. Longitudinal designs refer to repeated administration over time. A panel study is a type of longitudinal design in which the same respondents are contacted on several occasions. An alternative longitudinal design is repeated sampling from the same target population.

Cross-sectional surveys, in which data are gathered one time only, can provide some information for impact assessment but require the use of statistical controls. For example, a target population may include persons who participated in program activities, those who started but dropped out, and those who did not participate at all. The survey instrument includes outcome measures as well as measures of other variables considered relevant including level of program participation. Outcome measures are tested for a relationship with differences in the extent of participation and with the effects of other, relevant, possibly confounding variables held constant through statistical procedures.

Another application of this design might be the case where at different time periods or at different locations, there were differences in the intervention program. Statistical controls could be used to sort out these effects.

Well conducted cross-sectional studies as impact evaluation permit the collection of a large volume of data rapidly, easily, and inexpensively. They are useful in situations that do not permit before and after designs and do not permit experimental or quasi-experimental designs. They are useful especially where the target population is large. However, to be most effective, they must include adequate measures of the key variables. In the example given above, level of participation was the independent variable. Participants, dropouts, and non-participants self-selected themselves. To differentiate them effectively means being able to tap the key variables influencing self-selection in order to control for this effect.

Longitudinal survey designs collect data more than once. For example, a needs assessment may be used as baseline with a follow-up survey to determine extent of change. One such design involves repeated surveys of the same sample of respondents. This has the virtue of being able to chart the course of changes over time. Problems with this design include the attrition of respondents and sensitization. Attrition refers to the loss of respondents from the pool. They may drop out, move on, or refuse to continue participation. It is usually difficult to estimate in what significant ways they differ from those who remain in the pool. Sensitization refers to the fact that being in the respondent pool may alter the behaviors of the respondents in some way that cannot be estimated.

Repeated random samples from a designated target population also permit estimates of changes over time. This is particularly useful in controlling for the possibility of sensitization. It is also useful in situations where respondents' anonymity is a strong consideration. For example, adolescents who know that

they will have to be identified to be recontacted may not be forthright about some of their habits (See Application 7.3).

Survey methods can be particularly useful where it is possible to specify a clear independent variable as well as potential confounding and dependent variables. They allow for comparison on outcomes based on the status on the independent and control variables. However, where an intervention is aimed at a total social system–what Rossi and Freeman (1993) called full coverage programs–it may be difficult to specify values of an independent variable on which to base comparison among members. The method of time-series analysis may be applicable.

Time-Series Analysis: Time-series analysis is essentially a statistical procedure requiring baseline data sufficiently extensive and of sufficient duration to develop a model to project the course of a problem situation if not subject to an intervention. The results of post-intervention data are compared using statistical analyses to values projected by the model if no intervention occurred. While the technique is powerful, it requires strong theoretical understanding to model the phenomenon and an extensive pre-intervention database to construct the projections.

APPLICATION 7.3 Evaluation of AIDS Prevention Programs

In 1988, The Robert Wood Johnson Foundation (RWJF) issued grants totaling almost $18 million to 54 AIDS prevention and service projects in the United States and Puerto Rico. These projects were varied in target populations and risk behaviors, intervention activities and delivery techniques, organizational characteristics, and the amount and duration of funding. In 1990, a grant from RWJF was given to the University of Michigan and Hunter College to conduct a *process evaluation* of the 54 projects to identify lessons learned when implementing AIDS intervention projects (Janz et al., 1996).

A combination of qualitative and quantitative methods were used to evaluate the 54 projects. Quantitative data, in the form of survey responses, were used to answer questions about what intervention strategies were used and which were reported to be the most effective. Qualitative data from interviews and focus groups were used to identify and explain perceived intervention effectiveness and data from in-depth site visits provided case examples that helped explain the survey results. Together, the use of these different methods provided insights into which interventions were most effective.

Five intervention activities were rated as most effective. Small group discussion was the most effective intervention approach; it was used by 36 of the projects. The second most effective approach was outreach to high risk populations. The third most effective approach was the training of peers and volunteers who gave prevention presentations in the community. Providing safe Sex kits was a fourth intervention activity that was effective. Fifth was large group discussions.

Eight factors were identified as key in facilitating intervention effectiveness. These were:

1. Using culturally relevant and language appropriate interventions.
2. Embedding AIDS information into a broader context. AIDS has cultural, social, political and economic issues embedded in it.
3. Provide creative rewards and enticements by providing food, small amounts of money for getting tested, or providing academic credit for high school students who served as peer educators.
4. Building in program flexibility with choices of formats, schedules, and delivery methods to better suit target population's needs, skills and interests.
5. Promote integration into and acceptance by the community by working with the community, hiring from the community, and giving feedback to the community.
6. Repeat essential AIDS prevention messages several times to increase knowledge about HIV, its transmission and prevention.
7. Create a forum for open discussion by providing a safe place for candid discussions especially for children and adolescents.
8. Solicit participant involvement serving as peer educators, participating on planning and advisory boards, assistants in following up participants for evaluations.

Learning theory suggests that people are more likely to learn when messages are presented in multiple formats using different communication strategies. The AIDS projects evaluated all used multiple strategies, some more effectively than others. Small group discussions, with their emphasis on open communication and repetition of messages, are excellent opportunities for participants to learn and share information. The best outreach programs are those that are accepted by the target population, that combine rewards and enticements with appropriate language and delivery methods. The use of peer educators, in the case of AIDS education, helps overcome many barriers. The lessons that Janz et al. (1996) found are that AIDS prevention activities need to be flexible, tailored, repeated, credible, and involve the target population in the process of planning, implementation and evaluation.

Data Collection

To this point we have implied that data will be collected. Here again we must resort to general description and refer readers to other sources on instrumentation. The creative aspect of data collection is choosing the sources of data that will answer the necessary evaluation questions. Some of the choices for collecting quantitative data are: (1) behavioral observation; (2) tests, questionnaires, checklists, or rating scales; (3) archival data.

To be useful, measures must be reliable and valid. Babbie (2001) defined *reliability* as a matter of whether a particular technique, applied repeatedly to the same object, would yield the same result each time. Reliability refers to the stability or consistency with which a measurement device yields results. *Validity* refers to the extent to which an empirical measure adequately reflects the *real meaning* of the concept under consideration (Babbie, 2001). Note that the two dimensions are different. A measure may be reliable that is, it may consistently produce the same results, but not be valid. It may measure something very well but not what it is intended to measure. To be valid, however, a measure must also be reliable. Both validity and reliability are necessary.

Behavioral Observation: Data can be obtained through the direct observation of behaviors. This can range from relatively low judgment, concrete tasks of simply observing the presence or absence of a particular behavior or counts of the frequency of occurrence to more abstract and difficult judgments of qualities. Obviously, the former may produce greater reliability and validity than the latter. In the latter case, for example, interactive behaviors may be judged as supportive or antagonistic or somewhere in between. Validity and reliability can be improved with the training of observers, furnishing observers with operational cues of what to look for, and providing well designed data recording sheets. The use of more than one independent observer can also provide a check on inter-coder reliability. The more the observation task requires judgments, the more important it is to have multiple observers.

A variation of behavioral observation is analysis of the results of behaviors as in the content analysis of documents. Again, the use of multiple coders who have been trained in what to look for and who have a clear statement of the coding categories will improve the data.

Tests, Questionnaires, Checklists, and Rating Scales: Tests, questionnaires, checklists, and rating scales may be self-administered or interviewer administered. These instruments present the respondent with a question to which a response is desired. For some purposes, standardized instruments exist. Various kinds of academic achievement tests are an example. Where standardized instruments exist and are appropriate to the evaluation task, they can be useful because their reliability and validity have been established. Performance norms may also exist which provide a basis for comparison. Uncritical use, however, should be avoided when applying such standardized instruments with groups culturally different from those they were originally designed for and normed on. Class, race, ethnic, and language differences may make an instrument invalid or at least make the application of the norms inappropriate.

Instrument construction should be undertaken with great care. It requires a clear conceptualization of the dimensions of the variables of interest and how to measure them. Developers should also consider how respondents in the target group will react to being asked certain kinds of questions. This is especially relevant where culturally diverse groups are in the respondent pool. Some groups have different meanings for words or the culture frowns upon revealing personal or family information. Some issues may be sensitive and not talked about. Some

individuals and groups welcome the opportunity to express their feelings and opinions, others do not; others respond to the items the way they think they ought to respond, or the way they think the questioner wants them to respond. Finally, there is always the issue of what people say and what they actually do. An individual's self-report may be more or less accurate depending on the issue and how, when, where and by whom the question is asked. We call attention to these points to indicate that instrument and questionnaire development is not a simple task of writing up and distributing a set of questions.

Instruments constructed for the purpose of evaluation should be subjected to a rigorous development process. The items should bear a conceptual link to the variable it intends to study; items, language, and reading level should be appropriate to the respondent pool; biased wording, "double-barreled" questions, and ambiguous or vague terms should not be used; response choices should make sense in the context of the item. The issues of cost, respondent's time, and total time to gather data using the selected instruments are all important to consider.

A completed draft of the instrument should be pilot-tested on respondents similar to those for whom it is intended. This will provide information on problems of administration and understanding of items. If properly conducted, pilot-testing can also provide data for estimates of reliability and validity through item analysis.

Archival Data and Social Indicators: Most organizations, local, state and federal government agencies, and political subdivisions routinely collect data. These data can be useful in the evaluation of mesolevel and macrolevel interventions. Housing data, crime rates, economic indicators such as household incomes, employment data and workforce participation, productivity data, data from national surveys and opinion polls, health, mental health and social services data are only a partial list of what can be obtained.

Users of secondary data need to be alert to their limitations. For example, crime statistics such as arrest data refer to crimes known to police. Some crimes are not reported or arrests are not made. It is generally known that this under-reports the actual number of crimes. Not all crimes are reported to police. In addition, organizations and governmental units sometimes change their reporting and/or measurement procedures so that there appear to be dramatic changes in an indicator when, in fact, the change is due to changes in procedures. These data can be useful if handled with care.

Caveats

There are some caveats that should be noted as we close this discussion of evaluation. This short list of issues is by no means exhaustive nor does the order of presentation carry any implication.

The Pilot Study Problem: Sometimes a decision is made to begin a pilot program or demonstration project before planning the intervention. The reasoning is

clear. A small-scale program is tried to see if it works, to become familiar with the program, and to work out the kinks. This makes sense, especially where resources are limited. Evaluation is conducted on the pilot program, and the outcome is used to develop the full-scale program. This is where caution needs to be exercised.

Often pilot programs are run under optimum conditions. Program planners are particularly motivated and vigorous in their attempts to make it work. They pull out all the stops. Resources, both material and human, are abundant. The pilot program may be run by highly trained and qualified professionals. The small scale of the program may mean small staff-to-participant ratios. However, the operation of the full-scale program may be turned over to others, perhaps paraprofessionals or indigenous personnel. Ratios of staff to participants may be significantly greater than was true of the pilot program. In short, the experience of the pilot program may not reflect the actual conditions of the full-scale program. Evaluation of the pilot program needs to allow for the transfer of the program from test conditions to the actual conditions to be found in the field.

Implementation/Research/Competition: Weiss (1972:7) called attention to the fact that evaluation must take place while an intervention is in progress, which may cause conflicts between program and evaluation personnel. Personnel responsible for providing data and record keeping may also be responsible for program activities. Given conflicting demands for the worker's time and energy, the program is most likely to get priority–as it should. Conflict may exist where there is a division of labor between program people and evaluation people. Time for data collection, access to records, participants, and other evaluation steps may be controlled by program personnel who may consider evaluation as unimportant but necessary for justifying program funding.

Evaluation is not uniformly valued. Persons working to bring about change and committed to their efforts may see evaluation as evaluating them. They may see evaluation as a threat to their jobs or to a program they have designed and believe in. For these reasons sometimes program personnel are uncooperative or they may feel it is in their interest to withhold or contrive data.

Following the participatory model we espouse, some of this can be dealt with in the planning stage. In addition, problems such as these can be addressed in group sessions and ongoing dialogue among those involved.

Role Conflict: A potential role-conflict is the tension between sociologist-as-social scientist and sociologist-as-practitioner. We are all usually thoroughly versed in the canons of the scientific methods of our field. But evaluation is often done under time pressures. The designs are not always clean, the procedures and the data not always up to the standards of academic research. Moreover, unlike the academic researcher, the practicing sociologist may not have complete control over the research. Sometimes the rigor of evaluation research carried out in a practice setting falls short of what might be possible in a controlled scientific environment. One way of reducing judgments about the hierarchy of scientific vigor in evaluation research is for there to be more collaborative projects where researchers and practitioners both participate.

Summary

This chapter called attention to the need for including evaluation in all intervention. Evaluation is a guide to the development of intervention programs and as an assessment of both their intended and unintended consequences. A well conducted evaluation requires including the planning of evaluation as an integral part of planning the total intervention. Evaluation activities should begin when implementation of the program plan begins.

With evaluation as with all other phases of intervention, the interests and needs of stakeholders at all levels need to be identified and addressed. Evaluation should include stakeholders and participants from the beginning and as part of an overall client-centered approach to intervention. All concerned parties should participate in establishing the goals and objectives. They should be clear on the necessity for evaluation and participate in planning and implementing the procedures. As with all other phases of intervention, cultural sensitivity should be a part of evaluation. Respect for persons as individuals and as members of cultures and social systems must guide our activities.

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8
Ethics and Sociological Practice

Introduction

Ethics are norms for conduct that distinguish between acceptable and unacceptable behavior. Ethical norms are so ubiquitous that it is tempting to regard them as commonsense (Resnick, 1998). All people recognize some common ethical norms but different individuals interpret, apply, and balance these norms in different ways in light of their own values and life experiences. Many different disciplines and professions have norms for behavior that fit their particular aims and goals. These norms help members of the discipline coordinate their actions and establish the public's trust of the discipline.

The purposes of this chapter are to: 1) consider "What is an ethical sociological practitioner?"; 2) examine how principles of ethics apply at different levels of intervention; and 3) discuss some ethical issues in sociological practice.

Professional Codes of Ethics

Most professional associations have adopted specific codes, rules, and policies relating to ethical behavior and its enforcement. The American Sociological Association (ASA) has established such a code. The code outlines principles and standards that sociologists should use as guidelines when examining everyday professional activities. The code constitutes normative statements for sociologists and provides guidance on issues that they may encounter in their professional work. The code is also accompanied by procedures for filing, investigating, and resolving complaints of unethical conduct. Membership in the American Sociological Association commits members to adhere to the Code of Ethics and to the Policies and Procedures of the ASA Committee on Professional Ethics (www.asanet.org).

Five general principles serve as a guide for sociologists in determining ethical courses of action in various contexts. These are: professional competence; integrity; professional and scientific responsibility; respect for people's rights, dignity, and diversity; and social responsibility.

Code of Ethics for Practitioners

Two national sociological practice organizations, the Society for Applied Sociology (SAS) and the Sociological Practice Association (SPA) each have codes of ethics but are now drafting a common code of ethics to fit their new joint organization. In addition, practitioners who are additionally certified and/or affiliated with professional groups such as family and marriage therapists, mediators, alcohol and drug counselors and evaluators, also have their own set of ethical codes (Iutcovich & Hoppe, 2001).

Resnick has reviewed the ethical codes of numerous types of professional associations, agencies, and universities and has found common ethical principles that cut across most of them including: honesty, objectivity, integrity, carefulness, openness, confidentiality, respect for colleagues, competence, legality, social responsibility, human subjects protection, responsible mentoring, responsible publication, and non-discrimination.

The most fundamental value for sociological practice and for all forms of professional practice is the dictum: First, Do No Harm. This principle states that professionals have a duty to protect clients from harm. This charge forms the basis from which all practice values and all standards of ethical practice follow. Rokeach (1973) noted several values and ethical issues related to interventions that were consistent with the rule to do no harm: informed consent, the right to privacy, the protection of confidentiality, the prevention of physical and emotional harm to clients, the protection against deception, and the need for debriefing and educational feedback.

What Makes an Ethical Sociological Practitioner?

The preamble to the new draft Code of Ethics for the Association of Applied Sociology and the Sociological Practice Association reads as follows (www.aacsnet.org):

> . . . as sociological practitioners we are committed to increasing the knowledge of social behavior and to using this knowledge to promote human welfare and to address issues of societal importance. While pursuing these endeavors, we make every effort to protect the welfare of any individual, group, or organization we study or assist. We use our skills only for purposes consistent with these values and do not knowingly permit their misuse by others. While demanding the freedom of inquiry and communication, sociological practitioners accept the responsibilities that these freedoms require.

The Association has identified eight principles that elaborate on this Preamble. The eight principles are: 1) competence; 2) responsibility; 3) the welfare of research subjects, clients, and students; 4) confidentiality; 5) moral and legal standards; 6) statements about social concerns, policies, and programs; 7) statements about work and services; and 8) relationships with other professionals and institutions.

Competence

Competence refers to a practitioner's knowledge and skills and includes issues of training and credentials to carry out a specialized role. Competence addresses the question, "is the practitioner qualified to do what she proposes to do?" More specifically has the practitioner graduated from an accredited university, completed the training and experience necessary to be certified by accrediting bodies and/or specialty associations, and fulfilled the requirements for licensure, if appropriate?

Freidson (2001) pointed out that credentialism is a convenient and reasonably accurate way of identifying competence. He said that "full information is . . . one of the conditions considered essential for the operation of a truly free market. Only fully informed consumers are effectively equipped to choose among available goods and services in their own best interest. It is admitted that without full information that they may be at the mercy of others" (p. 205). He continued, " . . . even if full information were available about much of the work that professionals do now, not even the educated middle class could understand it and make fully informed choices" (p. 205). It is of critical importance that a practitioner fully disclose in lay language, to potential clients what a "sociological practitioner" is, and does, and how his/her knowledge, skills, and experience has relevance to the presenting problem.

Training and credentialing are not static attributes of a profession. Most professions require, to remain certified and/or licensed, that a practitioner has the obligation to keep their knowledge and skills current by accumulating a required number of continuing education hours in a specified timeframe, and being active in their profession's association and meetings. Some sociological practitioners have acquired additional certifications, for example as a therapist, mediator, or counselor, or have obtained degrees in fields related to sociology such as social work, or criminal justice. Continuing education is a requirement in these fields as well.

Some professional associations enforce the continued certification of their members by periodically randomly reviewing their continuing education records, e.g. National Board of Certified Counselors. The competence of practitioners is a key value in maintaining quality work and upholding the standards and reputation of the field. Finally, many universities require periodic post-tenure reviews for faculty. These peer-driven reviews are opportunities to encourage the continued productivity and involvement of senior faculty in their professions.

Competence is also implicit in the role of the client. It refers to the belief that human beings have the right to make decisions about what happens to them. A client may not be able to make decisions about their care for a variety of reasons including the ability to understand, or their age. The test of competency (preserving individual autonomy) varies from one context to another. In the instance of underage children, parents have knowledge and experiences that children lack, and it is often ethically appropriate for them to exercise their judgment on behalf of their children. In the absence of parents, proxy consent is needed.

Competence is more complicated when the planned intervention is, for example, a large group, corporation, or a community. Competency is usually assumed until circumstances indicate otherwise, therefore in situations where an intervention will affect a large group of people, each person who will be affected needs to be informed about the intervention, its effects on them individually, and to make a choice to participate or not. If the intervention is their place of employment there may be subtle, or not so subtle, pressure by leaders to obtain employee participation. In instances like this, employees' autonomy may be compromised. Bayles (1983) pointed out that the appropriate ethical conception of the client-practitioner relationship allows clients as much freedom to determine how their life is affected as is reasonably warranted on the basis of their ability to make decisions. As clients have less knowledge about subject matter, the special obligations of the professional become more significant.

The competence of practitioners is a key value in maintaining quality work and upholding the standards and reputation of the field. Competence also means that professionals are agents of power so they must be aware of their own limitations (Kelman & Warwick, 1978). When the problem situation is outside the professional's range of skills, training, and abilities, the most appropriate response is to make this known to clients as soon as it becomes evident and to offer an appropriate referral. This principle relates to the second, responsibility.

Responsibility

Responsibility goes hand in hand with accountability. To be responsible for the quality and outcomes of services is to be accountable for them. Responsibility applies to both the practitioner and the client, and may also apply to the institution the practitioner is affiliated with. Responsibility means that the practitioner treats the client with "due care." This may mean that the careful practitioner consults with other professionals in some situations. Failure to care constitutes negligence. Negligence is defined as the omission to do something which a reasonable person under the same circumstances would do or not do (Holder, 1978). A value that connects strongly with responsibility is competence – knowing what one is doing, knowing the limits of one's professional knowledge and skills, and knowing when to refer.

Responsibility also obligates a practitioner to follow-up on a client's progress. It is important that client's who have experienced a social intervention be checked on to see if they are following through on pursuing the activities or changes that they have committed to, and whether they have experienced new problems as a result of the intervention they recently experienced.

Sometimes interventions have unintended, harmful or reverse effects. Sieber (1981) noted that there can be reverse effects only if the consequences of an intervention are assessed. Many of the results of interventions are unknown or indeterminate, the data equivocal, or the effects only temporary.

Indeed, plans for follow-up should be part of the intervention plan discussed by the practitioner and client early on. Follow-up has its practical and economic

limitations. Nonetheless, follow-up is valuable feedback to the practitioner about how to become more effective.

Practitioners may not want to follow their clients for several reasons: 1) it extends the time expectations the practitioner had for the relationship; 2) the practitioner may not feel responsible for what happens after the formal relationship is considered terminated; 3) the practitioner may not want to know or be confronted with what didn't work and spend time dealing with those issues; 4) the initial agreement between the practitioner and client may not include follow-up; 5) follow-up does not give a clear time termination of the practitioner-client relationship; and 6) the practitioner does not have the time or resources to follow clients.

Some clients do not want to be followed. The boundaries between the intervention period and what might be considered intrusiveness may be a factor for both client and practitioner. Also, the kind and amount of information that might be obtained at follow-up is limited; therefore, depending on the type and extent of intervention, the information may be minimally useful to the practitioner.

Flaherty (1979) pointed out that an evaluation of outcome should be tied to a needs assessment completed at the initial agreement between the practitioner and client. The effectiveness of the outcome, therefore, will be determined by how well, or to what extent, the client's needs were met.

On a personal level practitioners assess how useful or effective they were in using their competence (knowledge and skills) to bring about a change in a situation judged to need intervention. Accountability to the practitioner is the moral evaluation of the intervention. Did the practitioner do what was agreed to be done, in a manner that respected the values of the client, and result in the changed client having retained their integrity? If interventions are viewed as partnerships both practitioners and clients need to be personally accountable, the former with the quality of performance and the latter with a belief in the practitioner and a commitment to the outcome.

On a legal basis practitioners are responsible to their clients and also to the institutions or agencies that sponsor their employment. Accountability on this level affects reputations, linkages with others, especially if the client was referred, and personal liability. Legal accountability means more than "getting everything in writing and witnessed," it means that the practitioner recognizes and assents to certain laws that protect client's rights and freedom to choose, and a willingness to practice within the context of legal constraints. Law may lag behind ethics in some instances, so interventions should be accountable both in terms of their legality and morality.

There is also a professional obligation to publish the results of experiences with client interventions as case studies, descriptive studies, or case-control studies (Hoppe, 2000). Sharing intervention experiences increases public knowledge, builds a current knowledge and skills base for the field of sociological practice, shares information with colleagues in aligned disciplines, and may encourage interdisciplinarity.

The Welfare of Research Subjects, Clients, and Students

Concern for the welfare of research subjects, clients, and students relates to respect for persons. Respect refers to the practitioners' recognition of each clients' personal worth. Often in relationships between professionals, research subjects, clients, and students, there is an implied status difference. The implication is that the professional is of higher status and has superior knowledge and skills and has the greater power in the relationship. Professionals show respect for subjects, clients, and students by developing a relationship with them as equal partners in the problem solving task. Competence is also a value in relationships with research subjects, clients, and students. It refers to the belief that people have the ability as well as the right to make decisions about what happens to them.

In a relationship with research subjects, clients, and students that is a partnership among equals, practitioners respect their autonomy and competence in making choices. Research subjects, clients and students are not dictated to. Nor are interventions imposed upon them.

With respect to clients, in order for a relationship to form there must be disclosure. Disclosure is a process based on trust. It is intricately related to how the practitioner and the client respect each other's differences. There must be enough congruence between the interests of the client and the practitioner to proceed to discussing "the presenting problem." Respect for each other will be demonstrated both verbally and nonverbally. One of the traits that will come through is truthfulness, that is, authenticity. A related characteristic that will become evident is honesty. These traits will help answer the question "Do I trust the other person?" Trust is the glue that sustains a relationship, but a preliminary assessment and decision to trust must occur in order to *begin* a relationship.

The issue of respect for a person is not always evident in client-serving organizations. While there are similarities to the dyadic professional-client relationship when a client seeks intervention through an organization, such as a social service or welfare agency, hospital, school, or university, the client usually is looking for a specific service or skill. Trust is a factor clients look for in seeking help, but given a client's circumstances, trust is often compromised. Client-serving organizations have reputations of trust. Luhmann (1979:88) said, "Without trust only very simple forms of human cooperation which can be transacted on the spot are possible . . . . Trust is indispensable in order to increase a social system's potential for action beyond these elementary forms." Once trust or distrust becomes embedded in cultural systems, they acquire functions and dysfunctions of their own. The culture of some client-serving organizations may be a limiting factor in how much trust can be established with clients. Strong norms and strong taboos that discourage flexibility and carry negative sanctions for staff and clients are likely to result in wariness and distrust between practitioners and their clients in client-serving organizations.

Organizations may not be sensitive to the values of individual clients, or if they are, they may be bound, by organizational culture, tradition, pressure from peers, or time constraints, not to deviate from a structured protocol for dealing with

categorized problems. Client-serving organizations are responsible for both their staff and their clients. Many client-serving organizations serve a mandate from a community, county or state and must legitimize what they do in order to attract funds. Therefore, professionals working in a client-serving organization may not be in a position of power or have much autonomy in their workplace. This will profoundly affect the entire process of interaction with clients and the degree of freedom the professionals have in giving choices to their clients, e.g. Health Maintenance Organizations. The client-serving organization, in general, is not one that initiates or accepts change easily. Clients who adapt to the client-serving organization's procedures are more likely to benefit from services; clients who don't adapt usually drop-out. Clients of organizations may not have the choice of other sources of help because of financial or other constraints and often remain unserved. The relative inflexibility of client-serving organizations and the limited options of their clients often create an intervention that is "forced" to fit the generic value systems of clients (Bidwell & Vreeland, 1977).

When clients are viewed within generic value systems their uniqueness as persons and their unique problems are often categorized. The options for intervention are limited by the organization and the client's life circumstances. This presents a challenging dilemma for the practitioner between what the client may need according to the practitioner's evaluation, what the client expects based on past experience or hearsay, and what the organization will permit the practitioner to do. There is no set protocol to guide a practitioner's professional behavior in such dilemmas. The best approach is to do no harm by not intervening to escalate a client's problem.

Confidentiality

Confidentiality is the recognition that information shared within the context of the practitioner-client relationship will be protected and not shared with others. The agreement of confidentiality is an expression of mutual trust. Much, if not most, of the process of establishing rapport and the quality of the relationship centers around confidentiality. Sociological practitioners function in a variety of roles and relationships including teaching, consultation, mediation, therapy and counseling. Some situations may require the sharing of some information with others, for example, consulting with a community about a racial schism, or mediating an organizational dispute, or conducting family therapy, may require that the practitioner and client discuss and agree on the limits of confidentiality; absolute confidentiality may not be possible, for example, what information the client might authorize a practitioner to give to an employer or insurance company. The principle of confidentiality operates on a need-to-know basis. There are exceptions to confidentiality: 1) exceptions commanded by statue law; 2) exceptions arising from legal precedent; 3) exceptions arising from a unique practitioner-client relationship; and 4) exceptions due to proportionality (public good). Professional secrecy is the most obligatory of professional relationships since its violation damages not only the client but the profession and the good of society.

A discussion about informed consent can only be meaningfully carried out after the practitioner and client have established an ethical foundation for their relationship. The knowledge and skills of sociological practitioners do not authorize them to control any aspect of another person's life or to limit the freedom of others. This is one of the underlying principles of informed consent. Some practitioners might consider the purpose of informed consent to protect themselves and their institutions from lawsuits. The second principle underlying informed consent is to encourage rational decision making, that is to protect the client from *iatrogenic* (practitioner induced) harm. This involves a procedure requiring practitioners to make certain disclosures in lay language to their clients before initiating any intervention. The procedure involves a brief, simple written and oral presentation of: 1) the proposed intervention; 2) alternatives to the proposed intervention; 3) inherent risks in the intervention; 4) problems anticipated in the intervention; and 5) additional information that should be disclosed. The client then signs and dates the informed consent form in the presence of a witness who also signs the form along with the practitioner. While the form is legalistic, it is also real in its consequences. Informed consent should also be an opportunity to dialogue about the benefits of the relationship and the expected positive outcomes of the intervention.

How informed consent is presented, discussed, and accomplished will vary with the client's circumstances. For example, different situations or contexts such as a community, a school, a family, a marital pair, or a teenager, will require modifications to how informed consent is presented, the options available to the potential clients, and obtaining proxy consents for underaged children.

Moral and Legal Standards

Awareness of prevailing community moral and legal standards and the impact of the practitioner's services on the conformity to, or deviation from, those standards is key to the practice of sociology. In other words, an intervention must be appropriate to the client's real world. The effects of interventions are not limited to the client or their personal boundaries. Interventions can create new problems or exacerbate related problems. For example, a 22 year old admitted himself to a Behavioral Health Unit following a suicide attempt with alcohol and other drugs. This was one of several previous such attempts to take his life. He lived with two other men who were unemployed and engaged in a daily routine of getting high. The client sought "advice" of how to break his cycle of drug use and become employable. One major theme in a continuing dialogue was the client's suggestion of the need to move away from his current friends. This meant that he would have to leave his two long-term friends and seek alternative housing and temporary subsistence. Being shy, withdrawn and lacking self-confidence he feared the inability to make new drug-free friends and hence, his return to drugs. This illustration shows that an intervention might require abandoning unhealthy neighborhood behavioral standards and learning a new lifestyle. The practitioner assisted the client in making choices that protected both the client's rights as well as public safety.

In another example, Slaten and her practitioner colleagues (2000) reported experiences in conducting ethics workshops on HIV/AIDS for mental health care providers in four Texas cities. Many of the participants had punitive attitudes towards HIV/AIDS patients, and were unclear about Texas law regarding disclosure and the confidentiality of medical information. The workshops had the effect of moderating participants' beliefs and views about HIV/AIDS. Participants appeared to have more compassion for persons with HIV and had a greater willingness to incorporate the consideration of patient's rights and welfare in decision-making. This illustration shows that knowledge, attitude and practice dimensions can be influenced by educational interventions for health service providers caring for HIV/AIDS patients. Therefore, sociological practitioners can impact the quality of health care in a conservative culture while being aware of, and sensitive to, prevailing community attitudes and beliefs about the sensitive topic of HIV/AIDS.

Statements About Social Concerns, Policies, and Programs

This ethical principle deals with the practitioner's dual roles as a professional and as a citizen. For example, as a professional a practitioner may have information (data) about community or societal problems such as racism, violence, crime, environmental issues or discrimination that are important that should be shared with policy makers. We also have the need, as citizens, to participate in dialogues about these problems and give voice to our opinions. Care must be given to distinguish between information that is professional and confidential versus information that is in the public domain. As professionals we will be privy to information that cannot be shared with others.

Mirvis (1982) reported his views and analysis of an ethical breach that occurred while he and a research team were studying work life in a Michigan corporation. Mirvis stated "as we began to design the study . . . it was recognized that another change had had a substantial impact on work life in the corporation: implementation of the (President) Carter Wage Guidelines. Hence we included in the survey some questions about the wage guidelines, how they were implemented, and how employees viewed them. This research yielded some significant and timely findings about the impact of the guidelines on morale, and my co-researcher and I agreed that these findings should be given a public airing. Without my prior knowledge he initiated a press release. Then our troubles started" (p. 198).

The news release created turmoil among the firm's managers who recommended that Mirvis' long-term study be stopped. The researchers had not violated the client's rights to prior review in letter, but they had violated it in spirit. The news disclosure resulted in the colleague being transferred to an off-site position. The researcher had violated the spirit of an agreement with a client organization and exposed them to possible harm.

This example shows the importance of continual dialogue between members of a research team, and between the team's leader and the client, or his/her representative,

at every stage of an intervention. This is essential at all levels of intervention, but critical at the meso and macrolevels where mis-communication can have immeasurable, and usually undoable, effects.

Statements About Work and Services

How practitioners make their services known will determine the referral routes of clients. Some clients may come for intervention at their own volition. Or the CEO of an organization seeks the consultation of a sociologist in turning around the negative effects of a major downsizing, which the CEO thinks he has handled "in the best way possible," but has resulted in a growing negative reputation for the corporation and a downward spiral in productivity, morale, and loyalty. There are also referred clients who are coerced to seek help by some legal authority. However, the majority of clients, hopefully, seek an intervention for positive reasons. It is important to discern the seriousness of a client's motivation for wanting change in the assessment phase. The most effective way to ascertain a client's motivation is to confront the client with discrepancies, inconsistencies, gaps, ambivalence or avoidance about disclosing certain information, and by observing nonverbal behavior that contradicts the client's story. The guideline of "If it doesn't sound right it probably is not right" usually is helpful in sorting out the truth.

The practitioner must demonstrate honesty, which will invite reciprocation from the client. Honesty is the foundation for a relationship that is free and open between the practitioner and client. Honesty is demonstrated by the practitioner in discussing the limitations of her expertise and possible need to refer the client. Honesty on the part of the client is evident when she admits that she has tried interventions previously that were unsuccessful because of her failure to accept responsibility for her problem. Honesty is essential in the first meeting of practitioner and client as it is then that the boundaries surrounding disclosure, truthfulness, and honesty will be put on the table. It is not ethical for either party to mislead the other into believing that behavior can be easily changed. Both the practitioner and client need to be honest about reservations they have regarding the relationship, intervention, and each other's expectations.

Autonomy affirms the rights of the parties involved. Most ethicists see rights as too self-oriented. Most rights also have duties. They imply each other. In any case the history of ethics has a strong tradition of duty ethics that overlaps with rights ethics. Discussing the issue of the client's degree of autonomy or freedom to choose the degree of participation in whatever intervention will be planned is essential. Clients will differ in the degree of autonomy they expect and practitioners will differ in the degree of autonomy they are willing to give. Therefore, a discussion of autonomy must include mutual expectations and boundary setting.

Strong (1983) pointed out that the right to criticize is a joint venture. Partners in a helping relationship should be free to ask questions, seek clarification, and for the client to obtain other professional opinions. In the case of parents, their questions are often information questions, or seeking reassurance, or guidance.

Relationships with Other Professionals and Institutions

Ethical sociological practitioners are focused on the client's concerns and needs, and as such, the practitioner is responsible for being knowledgeable about community resources that can assist in helping to resolve the client's problem(s). These resources include professionals in other disciplines, self-help groups, hospitals, clinics and other organizations that can provide services to meet the needs of clients with particular problems. Of critical importance is that the practitioner receive feedback about the effectiveness of these resources and the client's responsiveness to them so that the intervention plan developed for the client can be adjusted as needed.

Sociological practitioners can, in the course of joining community professional, social and civic organizations, make others aware of their professional skills and expertise and receptiveness to referrals. Becoming involved as a Board member of community organizations, making talks before community groups, and participating in community events can be ways in which the practitioner can establish her civic interests and demonstrate her commitment as well as for others to get to know the practitioner as a person who can be a valuable source of help. In other words, sociological practitioners need to develop social capital and social trust with professionals and institutions in the community in which they live and practice in order to become known, accepted and respected as an ethical professional.

Applying Principles of Ethics at Different Levels of Intervention

Although ethics codes and principles are important and useful, they do not cover every situation that arises in sociological practice, and they may conflict, and often require interpretation. It is important, therefore, to learn how to interpret, assess, and apply the various ethical principles that operationalize the Code of Ethics for sociological practice. One approach to learning how ethical rules apply in real life is to analyze situations that have occurred during interventions at the micro, meso, and macrolevels of practice.

Ethics at the Microlevel

The parents of a 26-year-old woman contact you because of your reputation as an effective drug counselor/therapist in the community. Their daughter was recently discharged from the hospital for the fourth time, following treatment for numerous and increasingly severe complications from her use of a variety of drugs, especially crystal methamphetamine. While in the hospital she refused to see a counselor from Behavioral Health, a social worker, or a chaplain. Her physician noted in his discharge note that, "if she did not seek help for her addictive lifestyle immediately she may not survive to see another hospitalization." The parents

were greatly distressed and pressured their only daughter to see you. The daughter's presenting problem was that "my parents want me to stop using drugs." The parents pledge their cooperation with your advice and suggested intervention. As a parent you have a son who used drugs as a teenager, but who responded to your strong guidance to join a 12-step program, and today is a non-drug using parent himself.

This vignette illustrates several ethical principles. First, in your initial assessment of the daughter you must determine her level of motivation and cooperation in making changes to her lifestyle. While you, as a parent, provided strong guidance to your son when he was a drug abuser, you are ethically bound not to impose your views on your clients. Indeed, any decisions about intervention must be mutual. From the tone of the client's presenting problem it sounds as if she came to see you because of her parents – she may not want to change her drug habits, despite the warning from her physician that she might not survive long unless she gives up drugs. Second, despite phone calls to you from her parents about their daughter's progress, you are ethically bound to confidentiality regarding what is discussed between you and the client. The client is an adult and has no legal responsibility to her parents; there is no need for you to report to the client's parents. Yet, you may want to explore with the client her views about involving her parents in periodic joint sessions. Third, if the client does consider interventions in her lifestyle she may be interested in alternatives other than seeing you, therefore, you should be prepared to refer the client if necessary. Fourth, if the client does not wish to continue to see you, you may want to offer her the opportunity to return at a later time.

What Is the Problem or Issue?

In this case the issue is you are visited by a drug abuser who has been pressured by her distraught parents to see you because a physician has told her that her prognosis with continued abuse is death.

What Is the Relevant Information?

The client, a young adult meth abuser, has had increasing hospital admissions with severe physical complications that are irreversible. Continued drug use will result in death. The client's parents are greatly distressed about their only daughter and want to seek interventions to keep her alive.

What Are the Different Opinions?

Little is known about the client's opinions other than she has refused visits by behavioral therapists, social work, and spiritual care while hospitalized. Insufficient information exists regarding family dynamics and parents' and client's patterns of interaction. Nothing is documented about prior interventions to

change the client's behavior or the circumstances preceding and following previous hospitalizations.

How Do Ethical Principles Apply to This Case?

In Chapter 3, Table 3.1 lists factors to assist the sociological practitioner in deciding whether to take the case or not. You may decline this case on the basis that the client came under pressure and probably is at high risk for dropping out of any treatment process. You may decide to refer the case, even if the client indicates some motivation to cooperate in changing her lifestyle. Confidentiality is essential. Information should not be given to the client's parents without the client's consent. The parents could join with the client and you in a joint session if all parties consent. Your responsibility and accountability are with the client. The client's autonomy and independence are respected. If you involve other professionals as part of the intervention plan the client must consent, along with the other professionals, about the sharing of information.

Ethics At the Mesolevel

A large United States based corporation has recently embraced the concept of a diversified workforce and has hired, for the first time in its history, workers from different ethnic and racial groups. However, the corporation began diversification without preparing its Caucasian workforce. Much turmoil has erupted as Caucasian employees were unprepared for this new policy and feel threatened; some of the newly hired employees speak little English, and tend to stay in cliques. The CEO has asked you to be a consultant to the corporation to suggest how to create a more tolerant and unified workforce. The CEO is aware of your excellent reputation as a sociological practitioner working with human relations problems in large corporations. The CEO expects a written report with recommendations in six to eight months.

What Is the Problem or Issue?

The sociological problem is what is the corporate leaders' conception of a diversified workforce? What were (are) the leaders' expectations of diversification? What role did Human Resources play in preparing the workforce for diversification? And what are the expectations and experiences of the non-Caucasian employees?

What Is the Relevant Information?

The client is the CEO of a large corporation and experiencing turmoil among employees since the firm began to diversify its workforce for the first time in its history. The CEO has asked a sociological practitioner to consult about how to create a more accepting and unified workplace.

What Are the Different Opinions?

No information exists, except rumor and hearsay, about employees' views and experiences regarding diversification. No information exists about management's views and expectations except they see the turmoil having a significant impact on morale, productivity, and the corporation's reputation. No information is known about diversification experiences in the companies with whom the client corporation does business.

How Do Ethical Principles Apply to This Case?

The practitioner, with the assistance of a team, will need to engage in a brief assessment to ascertain the CEO's expectations regarding a final report and recommendations. What are the constraints, if any, to the practitioner's access to people and information in the corporation? What is the expected timeframe for a report? This assessment would determine whether the practitioner would take the case, the need for a team to assist in information gathering, followed by a general plan with a timetable. Confidentiality of information gathered from all sources would have to be guaranteed. Informed consent would be used in respecting the rights of everyone regarding their willingness to participate in the study without consequences. The reason for engaging an outside consultant and the purpose of the study would have to be explicit and communicated to all employees. Why is the study being done and how will its results be used?

The practitioner will need a team of associates to help in the information-gathering phase. This team will need to be partners in the study and embrace the ethical principles of confidentiality and informed consent. The study team will need to adhere to strict boundaries of information-gathering so that there will be no personal opinion-giving or biases expressed to people contacted in the corporation. Some employees may decline to provide information and this must be respected.

The fact that a study of diversity is on-going may create rumor and apprehension. The CEO and practitioner team must, on an as-needed basis, offer reassurances about the importance of the study in improving the workplace and the observance of the principles of confidentiality and informed consent. Communication between the CEO and practitioner-leader must be open, continuous, and honest at all times.

Finally, it is important that honest feedback be given to corporate employees regarding the study recommendations, invite their comments, and solicit their involvement in turning negative factors into positive ones. How and why this should be done should be discussed with the CEO in the assessment phase.

Ethics at the Macrolevel

You have been asked by the Governor of California to design and carry out a study of his proposal that all persons resident in that state must have health insurance, even illegal persons. He has stated that if a person or family cannot

afford to buy health insurance, the state will help, but in order to obtain health care insurance is needed. The purpose of the study you will design is to determine the attitudes of Californians to this proposal, identify the key barriers to compliance with the proposal, and arrive at estimates of compliance. Findings from the study would be used to increase public opinion in favor of the Governor's proposal.

What Is the Problem or Issue?

The problem is to conduct a public opinion/feasibility study of the Governor of California's proposal to have a state-wide health care system for all residents that would be funded by health insurance purchased by residents with financial assistance from the state if necessary.

What Is the Relevant Information?

Quality health care in California is not uniformly available, affordable or accessible to all residents of the state. With increasing immigration this problem is becoming more acute. There is a lack of success in the United States government's attempts to tackle this problem on a national level, therefore California is proposing to solve its own problem.

What Are the Different Opinions?

Some people believe that immigration is the trigger for this problem and requiring health insurance for legal and illegal residents would be a way of identifying illegals. Others believe that insurance companies could charge excessive premiums making health insurance out-of-reach for the majority of working residents. Still others believe health insurance would ensure care, but not necessarily affect its quality.

How Do Ethical Principles Apply to This Case?

The proposal for universal health coverage could identify those who chronically overuse health services. It could be used to control the quality and quantity of services, costs, priorities for specialized care, and obligate consumers to practice prevention. Requiring health insurance would also be a way to make it mandatory for illegal immigrants to register, therefore perhaps discouraging immigration to California. The experience in California could serve as a pilot experiment for other states to try. Ethically the California experiment would establish moral and legal standards for health care, limit client's autonomy and confidentiality, and exert more control over the use of health care resources.

The ethical principles of sociological practice apply in our professional work and as professional persons at all levels, micro, meso, and macro. We must be continually aware that we are accountable personally, legally, and professionally for our competence, honesty and confidentiality.

Ethical Issues in Sociological Practice

An ethical dilemma is one that poses a conflict between two moral imperatives in which pursuing one would result in transgressing the other. Benjamin Paul (1953:441) defined an ethical dilemma for research sociologists when he said "participation implies emotional involvement; observation requires detachment. It is a strain to try to sympathize with others and at the same time strive for scientific objectivity." Regarding sociological practitioners Iutcovich and Hoppe (2001:71) asked, "can sociological practitioners take on advocacy roles without compromising their professional responsibility to remain neutral and unbiased? Can evaluators provide timely feedback without compromising objectivity?"

Resolving ethical dilemmas is rarely simple or clear-cut and frequently involves revisiting similar dilemmas. We search for skills, approaches, or models to apply to similar cases. Resolving ethical dilemmas is not about reaching the "right" decision; even among experienced professionals there may be no consensus or a single "preferred" course of action. It is more important to be clear about the basis of the decision and able to explain and justify how the decision protected client's rights and serve clients' best interests while upholding the values and standards of one's profession.

Ethical issues flow from and are embedded in the contexts of practice. Contexts of practice refer to the diverse social settings where interventions occur, i.e., the community, office, school, organization. To recognize, analyze, and resolve ethical dilemmas in sociological practice we need to be aware that sociological practitioners can have multiple roles and that their clients frequently involve more than one person. All ethical dilemmas are important whether they occur at the micro, meso, or macro level.

Confidentiality

Confidentiality is one of the most common sources of ethical dilemmas. The three cases presented earlier in this chapter all involve the issue of confidentiality. While there is an obligation to safeguard a client's trust, this obligation is neither absolute nor universal. There are times when obligations clash. Such clashes involve a conflict between confidentiality and the rights of the community, threatened third parties, and at times conflicts between preserving confidentiality with the client and not allowing the client to come to harm (Loewy, 1989). Clients are generally aware that certain conditions, for example, suspected human abuse and communicable diseases, must be reported. This is binding to both the practitioner and client as citizens and members of society. Safeguarding confidentiality at the risk of jeopardizing innocent people is no more appealing then violating a client's trust. Violating a trust can never be a good thing, but it can be a better alternative than allowing greater harm to occur.

The nature or context for delivering health services can create an ethical dilemma regarding confidentiality. Mattson and Brann (2002) raise concerns about confidentiality in managed care organizations as they become the dominant

approaches to health care delivery in the United States. While these organizations streamline efficiency they also compromise privacy by making patient's records available to a range of internal and external audiences. The authors raise the issue that the approach to protecting patient's confidentiality is now dictated by business interests rather than codes of ethical conduct. Even with confidentiality policies in place at health care organizations and with employees signing confidentiality agreements upon being hired, more breaches of confidentiality may occur simply because of the number of persons with access to confidential information.

Census data are important to sociological practitioners especially in research and evaluations. There is concern that as the issues of privacy and confidentiality gain more public attention, there will be less willingness of people to participate in the United States Census, or if they do, less honest in the information they provide (Prewitt, 2004). Attitudes towards the census that have been obtained through focus groups and other studies suggest six main public concerns: 1) not believing or understanding that census data are kept confidential; 2) the thought that the census asks for information that is an invasion of privacy; 3) concerns about, or were afraid of, interagency data sharing; 4) did not trust, or were afraid of, the government; 5) wanted to know how the census would benefit them; and 6) were afraid that census data would be used against them (Mayer, 2002). There is a fair amount of consistency in the concerns reported in focus groups over the past few decades from the 1970s to the 1990s (Martin, 2000). Concerns focused around both privacy and confidentiality. In one study of the 2000 Census, concerns about privacy and confidentiality increased after forms were mailed to households (Martin, 2000). Yet, there are mixed results about the effects of privacy and confidentiality concerns on security and census response rates (Martin, 2000). While the Census Bureau has not experienced wide-scale resistance based on privacy and confidentiality concerns, there is the potential as has occurred in several other countries. The dilemma is how to inform the public and build and maintain trust in the United States Census and its confidentiality practices, while at the same time not increasing fear about violations of privacy.

Advocacy vs. Neutrality

Since the major problems of our society, and the world, are predominately sociological problems, should sociological practitioners, as professionals and citizens, take on advocacy and leadership roles in helping to solve and prevent these problems? As Iutcovich and Hoppe (2001:71) stated "many sociological practitioners enter applied and/or clinical work because . . . it is something they can do to 'make a difference.' " Indeed, a Task Force on Institutionalizing Public Sociologies has submitted recommendations to the Council of the American Sociological Association on public sociology. Public sociology is a sociology that seeks to bring sociology to publics beyond the academy, promoting dialogue about issues that affect the future of society (American Sociological Association, 2005). Journalists and social scientists recently met so that journalists could better understand what social

scientists do and how that could be better disseminated to the public (Fenton, Deacon, Bryman, & Birmingham, 1997). Policymakers have also expressed interest in sociologists contributing to policy debates and providing guidance in the design of studies in areas such as health policy (Gray & Phillips, 1995). Burawoy (2004) recently pointed out that a strong professional sociology provides the foundation for good policy work, and good policy research has shaped and constantly revitalizes professional sociology. Professional, policy, and public sociology should be complimentary to each other in accountability to both the academy and the public.

The Limits of Informed Consent

Informed consent is understood differently by various disciplines and professions. Marvin (1990) pointed out that "not knowing the extent to which informed consent must be applied is a problem faced by ethically sensitive sociologists."

Consent is vulnerable to conflicting interpretations based on personal and social beliefs about human nature (Alderson, 1998). Informed consent stems from the legal and ethical right an individual has to decide what is done to them. Consent is understood and discussed in contradictory ways when people rely on different theoretical models. Real consent reminds practitioners and researchers about standards that protect them and their clients; these may be too high to achieve, but they remain standards to aim for. Functionalist consent reflects common sociological practice and values. Social construction shows how consent is a process, shaped through the interactions between individuals and their social contexts. Consent is much more complex than any one theoretical model (Alderson, 1998).

Consent is focused around two major components: understanding and voluntariness. The obligation to obtain informed consent before proceeding with an intervention involves an obligation to communicate information that is understandable to enable a client to make choices based on an understanding of the consequences (See Table 8.1). Respect for informed consent has benefits. It encourages professionals to be accountable and to know and explain clearly what they plan to do, and why. Respect for clients' consent or refusal acknowledges their physical and mental integrity. It defends clients against unwanted interventions or coercion during intervention or research.

How much information is adequate when discussing an intervention with a client? There are three aspects to this question: 1) what the typical sociological practitioner would say about the intervention; 2) what an average client would need to know to be an informed participant in the decision; and 3) what a client would need to know and understand to make a decision that is informed. The key is that a client receive enough information on which to base informed consent. It is the responsibility of the practitioner to discuss details with the client as necessary for clarification and understanding. Clients differ in personalities, emotions, level of education and cognitive status. If a client can restate the information they have been given, this will help in confirming that he/she has received enough information and understood it.

TABLE 8.1. Types of informed consent.

Informed consent involves:

- The nature and purpose of the intervention
- Intended effects and unintended effects
- Risks, harms, and hoped-for benefits
- Any reasonable alternatives

Voluntary consent involves:

- Freedom from force, fraud, deceit, duress, overreaching or other forms of constraint or coercion
- Knowing about the right to refuse or withdraw
- The right to ask questions and to negotiate aspects of the intervention

Consent to research involves:

- The purpose, questions, aims and methods of the research
- Relevant terms like "randomize"
- The intervention, if any, which the research proposes to do
- Benefits, risks, harms, or costs to research subjects
- Hoped-for benefits to other groups and clients
- Confidentiality, indemnity, sponsors, ethical approval
- Who the research team is and a named contact

Sometimes collective or group consent is needed in sociological practice, for example in organizations and communities. Individual consent is replaced by democratic consent. In some communities leaders may make decisions for those they govern. However, group consent does not compel individuals to give their personal consent, for example in community-wide surveys or door-to-door interviews.

Even though standards and procedures have been closely followed, there is always a degree to which informed consent must be assumed or inferred based upon observation or knowledge. It is the responsibility of Institutional Review Boards (IRBs) and Institutional Ethics Committees (IECs) to minimize gaps, inadequacies, and uncertainties in practice and in research in institutional settings.

Interventions with Diverse Populations

Marshall and Batten (2003) discussed ethical issues that are becoming increasingly important for sociological practitioners as the United States becomes more culturally diversified. There are often multiple social and cultural differences among practitioners or researchers, among clients or research subjects, and between practitioners, researchers and their clients/subjects. Differences in cultural values and norms impact informed consent, confidentiality, approaches to collecting information and data, participant roles, group representation, and the use of information and data.

Literature suggests that marginalized and minority populations frequently report feeling misunderstood by intervenors from the mainstream culture (Hudson & Taylor-Henry, 2001; Sue & Sue, 1990). A high level of cultural awareness on the part of the intervenor is associated with rapport building and fostering relationships

with minority clients and research subjects (Stubben, 2001; Westwood & Ishiyama, 1990). Pedersen (1991) suggested that no two families, or groups, are ever culturally the same; each group internalizes aspects of cultural norms of the group in its own way. Also, social environmental factors such as racism, prejudice, economic status, and level of acculturation greatly influence developmental tasks for youth and children from minority cultures. Interventions must, therefore, be based on an understanding of diverse cultural dynamics.

Practitioners and researchers need to seek congruence between their own views and those of the group or culture that is the focus of an intervention. Informed consent requires special consideration. In some cultures ethics is a more fluid concept and requires periodic review. The letter of consent is often viewed as only one aspect of the process of consent, which includes the importance of the relationship with the intervenor(s) and the experience itself.

Respect and continuous communication are essential in building partnerships across cultures, especially with respect to the issue of control. Control relates back to informed consent where the purpose and method(s) of intervention were first addressed. Concerns about power or control center around who makes decisions, for example, about research processes, methods, data collection, analysis, and use of results. Ideally there should be a collaborative and agreed-upon decision-making process, but some groups may not be able to make such decisions. The key, as Marshall and Batten explained, is the power of the process. If the process focuses around respectful, synergetic, and mutually beneficial aims, then cross-cultural differences become an asset rather than an obstacle.

Summary

Ethics is the centerpiece of sociological practice. Sociological practitioners are committed to the Code of Ethics of the American Sociological Association and to the Code of Ethics of the common code of the Society for Applied Sociology (SAS), and the Sociological Practice Association (SPA). The codes of ethics themselves do not make ethical sociological practitioners. Codes outline the principles or standards to which sociological practitioners, as a group, aspire; the greater responsibility lies with the behavior of every practitioner.

This chapter discussed in detail eight ethical principles of the SAS and SPA and illustrated, through vignettes, how these principles applied at the micro, meso, and macro levels of intervention.

There are many examples of ethical issues in contemporary sociological practice. While some ethical issues will vary with the type of activities practitioners engage in, there are issues that cut across all forms of practice, for example, confidentiality; the advocacy vs. neutrality role of practitioners; the limits of informed consent; and interventions with diverse populations.

Codes of Ethics are written to guide behavior. They increase the probability that people will behave in certain ways. Effective codes allow people to test their actions against expected standards. Over time this kind of behavior becomes a

habit and is ingrained in the organization. Codes of ethics do not take away from individual autonomy, rather they offer strong reasons to act in certain ways.

Codes of Ethics serve as professional statements to a set of moral standards. Effective codes are not merely text, they spell out relationships with clients, other professionals, and the public. No code will make bad people good. However, codes have an impact on the behavior of bad people in organizations. When everyone knows the standards of an organization they are more likely to recognize wrongdoing and do something about it. As such, individuals are more likely to think twice about engaging in behavior they know is unethical and everyone around them knows is wrong. Indeed, corrupt individuals believe that they are more likely to get caught in organizations that emphasize ethical behavior. As Mark Twain (1901) said, "always do right . . . this will gratify some and astonish the rest."

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Glossary

Accountability: Often used synonymously with responsibility, answerability, and liability with the expectation of account-giving.

Adaptation: The adjustment of individuals or social systems to conditions and to changing conditions.

Antecedent Conditions: Conditions or events that occur before and may have a causal influence on subsequent events or conditions.

Archival Data: Information kept as records of organizations and institutions such as courts, justice, medical, or school systems.

Assessment: The process of gathering information about a case for the purpose of planning and developing a program of change or problem solution.

Attention-Deficit/Hyperactivity Disorder (ADHD): A condition characterized by behavioral and learning disorders.

Baseline: The measured preintervention status or condition of a case.

Binuclear Families: Is the extended family, usually consisting of two separate households, formed by the children and subsequent spouses of the partners in a divorce.

Biopsychosocial Perspective: A point of view that studies human behavior as the complex interaction of biological, psychological, and social factors.

Blended Families or Stepfamilies: Acquired when a parent marries someone new; stepfamilies are formed out of a loss.

Boundary: Physical, social, and psychological barriers that limit movement or thought. That which divides a system from its environment.

Case Study: An intensive, detailed description and analysis of a single project or program in the context of its environment.

Client-Centered Approach: A humanistic approach to working with clients that is nonjudgmental and emphasizes respect for client's autonomy.

Clinical Approach: Usually refers to the process used by a professional who follows a protocol for diagnosing or assessing a presented problem, and outlines a plan for intervening to improve a person's quality of life.

Clinical Judgment: The mental capacity to assess situations or circumstances and draw sound conclusions or opinions after consideration or deliberation.

Closed Systems: Systems that do not interact with their environment, that do not exchange information, material, and/or activity with their environments or other systems.

Co-Actors: People who work on the same noncompetitive task at the same time.

Community Health Governance Model: Recognizes the importance of collaboration in transforming and strengthening the public health infrastructure.

Concomitant Variation: When changes in the measured value of one variable are associated with changes in the measured value of another variable.

Confidentiality: A component of ethical practice that requires that clinicians safeguard information obtained from clients, students, or research subjects except, perhaps, when to do so may result in harm.

Cultural Sensitivity: An awareness of the nuances of one's own and other cultures.

Decision Tree: A schematic way of representing alternative sequential decisions and the possible outcomes from those decisions.

Deviant Behavior: Behavior that violates social norms.

Dialetical Relationship: The tension or opposition between two interacting forces or elements.

Dysfunctional Individuals: Persons who have difficulty in conforming to the norms of a family, group, social institution, community, and/or society, and may have difficulty in meeting their own needs for basic survival.

Ecosystem: A system in which living things are interrelated with each other and with their shared environment.

Empowerment: To give authority or delegate moral or physical actions to a group.

Epidemiology: A field of inquiry directed at determining the distribution and etiology of disease. The epidemiologist attempts to determine who develops a specific disease and why.

Equifinality: A property of open systems that refers to systems' independence from their initial states. That is, two systems with the same initial states may produce different outcomes; two systems with different initial states may arrive at the same outcome.

Experimental Design: A research design that requires that subjects be randomly selected and randomly assigned to treatment conditions, that an investigator carefully control presentation of experimental conditions, and that among the conditions there be a no-treatment control group, established as similar to treatment groups, against which the effects of the treatment will be compared.

Family Affect: Refers to feelings or emotional responses expressed by a family, individually and collectively.

Family of Origin: Refers to one's birth parents.

Family Power Structure: Refers to the "pecking order" of the family with respect to decision-making.

Family Rules: Implicit and/or explicit guidelines for accepted behavior among individuals living together as a social unit.

Family Role Structure: The identifiable pattern of relationships and roles (who does what) in a family.

Feedback: The return of information material, and/or energy to the system as input.

Focal System: The system under study.

Genogram: An intergenerational schematic of a family used as a tool in assessment with individuals and families.

Hawthorne Effect: When clinicians or investigators knowingly or unknowingly change the situation or behavior they wish to observe or study.

Health Promotion: Strengthening parameters of living (behavioral, physiological, environmental, genetic, social) to minimize the risk of health problems.

Homeostasis: The property of an open system, especially living systems to regulate its internal environment to maintain a stable, constant condition by means of dynamic equilibrium adjustments.

Human Ecology: An academic discipline that deals with the relationship between humans and their natural environment. Human ecology investigates how humans and human societies interact with their environment.

Iatrogenic: Introduced inadvertently by a professional and their treatment.

Identified Patient: The individual who receives attention, care, or treatment.

Idiographic Explanation: Explanation of a unique case or situation.

Impact Evaluation: The assessment of the effects, both intended effects and unintended effects of an intervention or treatment program.

Input: The information, energy, and/or material introduced into a system from its environment.

Intervenor: The person who introduces a technique or method to introduce change.

Intervention: A technique or method to introduce a change in attitude, behavior, or environment.

Intervention Outcome: The results or effects of introducing a technique or method to bring about change.

Key Respondents: Identified members of a group under observation who agree to talk to the observer about the group and its activities.

Labeling Theory: The assertion that deviance and conformity result not so much from what people do as from how others respond to those actions.

Latent Consequences: The unrecognized and unintended consequences of any social pattern.

Macro-Micro Continuum: The organization of sociological phenomena on a continuous scale ranging from large-scale social systems (macrosociological) to individuals and small, primary groups (microsociological).

Macrosociology or Macrolevel: The sociological study of large-scale social systems such as whole societies or cultures or social institutions.

Manifest Consequences: The recognized and intended consequences of any social pattern.

Mediation: The act of interposing or serving as an intermediary.

Microsociology or Microlevel: The sociological study of individuals and/or small primary groups.

Mesosociology or Mesolevel: The sociological study of midlevel collections of people in secondary groups such as organizations and social networks.

Model: A representation or likeness of something that is real which is used for the purposes of analysis and understanding.

Moral Judgments: Attitudes held by a speaker, with the intention of inducing similar attitudes, and corresponding actions, in those to whom the judgments are addressed.

Niche: The place or function an entity occupies within an ecosystem.

Nomothetic Explanation: Explanation based on general principles of classes of events.

Nonsummativity: A property of open systems that indicates that the system is more than the sum of its parts and that the system cannot be understood simply by analysis of its parts.

Open Systems: Systems that interact with their environment; they exchange information, material, and energy with their environment.

Organizational Decline: Refers to the lifecycle of organizations, which, like individuals, change with age and circumstances. Decline is a change over time from previously efficient to inefficient functioning.

Output: Information and other resources introduced into the environment from a system and available to other systems within the environment.

Parentalized Child: A child who assumes the responsibilities and functions of a parent in caring for siblings.

Person-Environment Fit: A relationship between an individual and his or her various environments. "Fit" refers to how satisfying this relationship is to the individual. A poor fit is thought to lead to stress and its negative consequences.

Personal Values: The code of beliefs and criteria for decision-making that mold individual behavior.

Placebo Effect: An intervention or treatment that has no specific direct effect, e.g., taking a sugar pill instead of a medication.

Presenting Problem: The initial problem as stated by clients.

Primary Prevention: Averting the occurrence of an action or disease at the principal site, for example, by not smoking cigarettes or by immunization.

Process Evaluation: A process evaluation focuses on what activities were provided to whom and how. Its purpose is to describe how the program was implemented—who was involved and what problems were expressed.

Prochoice Movement: Favors or supports the legal right of women and girls to choose whether or not to continue a pregnancy to term.

Program Evaluation: Uses objective measures to determine how effective the program was in reaching its goals and to make decisions about the program's retention and improvement.

Prolife Movement: Advocates the full legal protection of human embryos or fetuses, especially by opposing legalized abortion.

Program Monitoring: A part of program evaluation that takes place while program implementation is underway that is designed to determine if the program is moving toward the planned objectives.

Problem-Solving Justice Model: Focuses on innovative ways to resolve legal problems, using problem-solving courts and public problem-solving methods such as community policing.

Public Sociology: A recent current movement within American academic sociology to push the discipline more deeply into issues of public importance and to do so in ways that are accessible to popular and lay audiences outside of academia.

Quasi-Experimental Designs: Research designs that attempt to approximate the experimental design but cannot meet all the requirements, especially random assignment to treatment and control groups.

Random Assignment: The unbiased assignment of subjects to treatment groups strictly according to chance; the assignment of subjects to groups such that each subject has an equal chance of being assigned to any group.

Random Selection: The unbiased sampling of cases from a population such that each element of a population has an equal chance of being selected.

Role Model: Refers to a person who fills his or her role as a good or bad example for them. A good example is a positive role model. A bad example is a negative role model.

Role Performance: Refers to the way an individual performs or functions while acting in a particular role.

Sandwich Generation Families: A generation of people who give care to their children and their parents at the same time.

Script-Based Intervention: Follows a prescribed protocol for an intervention to provide structure, consistency and reduce bias.

Social Norm: A rule that is socially enforced. A norm can be a standard that a society expects or accepts; a thought or conduct approved by society.

Social Systems Approach: Seeing human behavior and that of social groups as the result of multiple interacting internal and external factors.

Social Systems Model: A way of looking at the interrelationships between people and their environments.

Social Values: Values that affect the individual's relationship to society, such as the ideals of caring for others, respect toward others, sharing, helping, etc.

Sociological Spectrum: The Macro–Micro Continuum: The ordering of sociological phenomena on a continuous scale from large-scale to small-scale social action.

Stakeholders: Persons who are affected by a program and/or evaluation of that program.

Steady State: The state that occurs when the whole system is in balance; the system is maintaining a viable relationship with its environment and its functions are being performed in such a way as to ensure its continued existence.

Superordinate Goal: A goal introduced with the aim of reducing tension and conflict in a group and to lead to the integration of the group.

Synergy: The combined action of all the parts of a healthy system.

System: A set of elements that are functionally interrelated such that the action or state of any element affects all the other elements and the system as a whole.

Systemic Solutions: Interventions that bring about the harmonious, orderly interaction of a group or network of interacting, interrelated, or interdependent elements.

Systemic Problems: A group or network of interacting, interrelated, or interdependent elements forming a complex whole.

Tacit Knowledge: Conveyed indirectly without words or speech.

Theory: A set of well-established propositions or statements that explain some class of events or phenomena.

Transitions: Changes usually predictable and planned such as transitions in the process of aging. Yet some transitions can be the result of unexpected changes such as loss of roles.

Value System: An enduring organization of beliefs concerning preferable modes of conduct along a continuum of relative importance; they are perceptual filters.

Values: A value is an assessment of worth. Good, bad, right, wrong, should, ought to, are value words that express moral judgments of what is desirable, preferable, important, and appropriate.

Values Clarification: Enabling one to take off the blinders of prevailing mores and examine values without pressures or influences.

Value Free: The illusion that an individual is free from bias or subjective assumptions about others.

Value Conflict: Dissonance between sets of values held by an individual, between individuals, groups, etc.

Wholeness: A property of systems that indicates that all parts of a system are functionally interrelated and the system functions as a whole.

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